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Department of Public Health
City Hall, Toronto, Ontario, Canada M5H 2N2

A. S. MACPHERSON, M.D., M.Sc.,
Medical Officer of Health

Reply Attention:

Telephone: 367-7401

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March 6, 1983.

Barbara J. Blake, M.D., D.P.H.,
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Ministry of Health,
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M4H 1A9

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Dear Dr. Blake:

In reference to your letter of January 6, 1983, I am enclosing the City of Toronto Department of Public Health response to the Ministry's Draft Guidelines for Mandatory Health Programs and Services.

Yours truly,

A.S. Macpherson, M.D., M.Sc.,
Medical Officer of Health.

cc: Tom McFadden, Director,
Association of Ontario Boards of Health

Local Board of Health ✓

Encl.

/sa

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CITY OF TORONTO
DEPARTMENT OF PUBLIC HEALTH

February 18, 1983

RESPONSE TO MINISTRY OF HEALTH DRAFT GUIDELINES FOR MANDATORY HEALTH PROGRAMS AND SERVICES

INTRODUCTION

Re p. 3

IMPLEMENTATION

The implementation section for each mandatory health program includes the development of an operational plan. It presently is worded as follows:

> "The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard."

We suggest that in order to ensure that the operational plan reflects a unified approach, based on agreed upon priorities, this section be expanded as follows:

> "The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard in consultation with all the disciplines involved in each program. This would ensure that the plans are interdisciplinary, consistent and coordinated and that delivery and resources are available."

Since an operational plan appears in the guidelines for all programs, it would be appropriate to include also the foregoing as an overall statement in the INTRODUCTION - possibly on page 3.

COMMUNITY SANITATION

PART I

INSPECTION OF PREMISES

Re p. 6

STANDARD

A literal interpretation of the terms "minimum level of service" suggests an element of latitude and flexibility whereby the frequency of visits, as illustrated on pages 8 to 11, may be increased, or modified, in response to a particular community need. On the other hand, the possibility that these stated frequencies may have significant funding implications should not be ignored, particularly during the current atmosphere of economic restraint. The Ministry could quite legitimately take the position that our program funding is based on the minimum number of visits, and the cost of any additional visits would not qualify for approved program funding.

This point has been discussed with representatives of the Ministry on a number of occasions during the past several years. Our argument for an increased number of visits, an argument which incidently was accepted, was based on the fact that our community, particularly our food premises, services a large portion of the Metropolitan Toronto population. This high volume of patron traffic generates a higher than usual complaint rate, and requires a correspondingly higher degree of surveillance.

It is interesting to note that the Ministry, early in the process of developing the mandatory program guidelines, recognized the need to provide the various health agencies with the required latitude. Page 2 of the document entitled "Program Guidelines for Core Program Project - Phase I" (April 1981), very clearly supported the need for flexibility. Regrettably, however, that provision which formed part of the original Program Goal statement was omitted in the December 1982 draft document.

We view the Ministry's failure to recognize the need for a user-specific health information/data support system as a glaring omission. In our opinion, such vital support services warrant mandatory program recognition. The Ministry obviously continues to operate with the misguided belief that information/data systems remain their exclusive domain, notwithstanding the fact that many of their current systems fall short of meeting the needs of this and other agencies.

It is our understanding that Woods Gordon, Management Consultants, have completed their review of the Ministry's data capabilities, and have tabled a report which recommends some significant changes. In the absence of reviewing this document, we cannot comment further on whether their proposal offers any beneficial improvements to the existing systems.

COMMUNICABLE DISEASE CONTROL

PART I

HOSPITAL COMMUNICABLE DISEASE CONTROL

Re p. 22

STANDARD

We recommend the following changes:

(1) Amend to indicate that consultation to hospitals should be provided at the discretion of the Medical Officer of Health, and therefore should be "when appropriate", not "when requested."

(2) Delete the phrase "in accordance with hospital bylaws", and if there is indeed a conflict with hospital bylaws, then the Ministry should insist that the bylaws be amended accordingly.

Re p. 23

IMPLEMENTATION

(3) Program Delivery

We recommend that, in order to avoid confusion regarding responsibility and to assist in epidemiology, the following be added:

"(d) The investigation and control of any outbreak of a designated communicable disease, which appears to be confined to the hospital, should be notified to the Medical Officer of Health and conducted in a manner acceptable to the Medical Officer of Health."

COMMUNICABLE DISEASE CONTROL

PART II

IMMUNIZATION

SECTION A

GENERAL

Re p. 24

The whole thrust of this section appears to be to get health departments more involved in provision of immunization. While we must have the authority and the capacity for immunization, we should also be educating people to use the existing health care system.

STANDARD

This section requires us to ensure the availability of immunization services, including the provision of information, the administration and practices, and the operation of immunization clinics. In general, we already do this, and it must remain to be seen whether we will need to operate additional immunization clinics to meet this standard.

IMPLEMENTATION

(1) Program Administration

We recommend the following changes:

(b)(ii) Amend to read "number of doses by vaccine distributed by the Board of Health to private physicians, where this is not currently done by the Ministry of Health."

In addition, another section should be included here that would enable us to monitor the utilization and wastage of vaccine. It should read "number of doses, by vaccine, wasted, discarded, or returned by the health agency".

(b)(viii) Amend to include the "lot number" so that adverse reactions and vaccine failures can be traced and monitored.

Re p. 25

(3) Program Delivery

One new requirement is that immunization services "shall be available to all persons residing in the health unit including those persons residing in institutions". This presumably includes the provision of immunization services to jails, nursing homes, homes for the aged, homes for the retarded, group homes, etc. This represents a new activity for the Department which will probably require some additional expenditures and staff, depending on how it's carried out.

COMMUNICABLE DISEASE CONTROL

PART II

IMMUNIZATION

SECTION B

IMMUNIZATION OF SCHOOL CHILDREN

Re p. 26

STANDARD

Much of the work under this Standard is incorporated in the Immunization of School Pupils Act. One departure from this Act seems to be Standard (2), which requires that we offer and provide immunization to all children entering school for the first time and to those children attending school who may not have been immunized or who require a booster. This appears to include private schools, which we were not intending to do. The Immunization of School Pupils Act only requires us to monitor immunization status, not to provide that immunization. This Standard presumably would require us to provide immunization to all children in private schools, which would entail considerable additional workload and expenditure.

Also in Standard (2), we recommend the word "provide" be replaced by "to ensure provision of". In keeping with other sections of the guidelines, this could then be considered to mean that families should be encouraged to make contact with their family physician. This also applies to Section C, Standard (2).

It is noteworthy that Standard (3) requires the immunization program to offer immunization against Pertussis, although this is not included in the Immunization of School Pupils Act.

IMPLEMENTATION

Re p. 26

(1) Program Administration

We recommend in subsection (b) an additional item for the record, namely, the number of school entrants for whom medical or religious exemption forms are completed.

Re p. 27

(3) Program Delivery

(d)(i) This subsection recommends that assessments be completed within two months of a child's entering school for the first time. While this recommendation may be appropriate for Canadian children moving from coast to coast, it does not take into account the large population of children who immigrate to Canada. In such cases it could take 3 to 4 months to obtain immunization information. This subsection should be amended by adding "unless there are exceptional circumstances".

(d)(ii) The requirement that immunization updating be completed within one year is not attainable since a complete series and booster requires 18 months. This should be amended to read "two years".

(e) Does "home instruction" mean children who are kept at home by their parents during the early part of their education, as well as those who are convalescing and receiving home instruction from an itinerant teacher?

Does "in care and treatment institutions" include the child in hospital with a long-term illness or the student at Sunnyview School? This subsection should be amended to include a definition of "home instruction" and "in care and treatment institutions".

COMMUNICABLE DISEASE CONTROL

PART II

IMMUNIZATION

SECTION C

IMMUNIZATION TO CHILDREN IN LICENSED DAY NURSERIES

Re p. 28

STANDARD

Standard (1) requires us to assess the immunization of children entering licensed day nurseries, which is something we already do under the Day Nurseries Act. However, Standard (2) requires us to provide immunization to all children entering licensed day nurseries for the first time. This immunization program is to include Pertussis which is an additional workload and will require additional staff. This Standard appears to be an attempt to extend the Immunization of School Pupils Act to Day Nurseries. The administration of this program, including the record-keeping, will require additional resources. We do not presently provide this information for day nurseries and this again would entail additional work.

PREVENTIVE DENTISTRY

PART I

FLUORIDE PROGRAM

Re p. 32

STANDARD

(3) This requires a fluoride program for communities where the level of the fluoride in the water system is below 0.7 ppm. Given the recent difficulties with maintaining such levels in Metropolitan Toronto due to shortage of supplies of fluoride, at what point are health units required to provide a supplementary program? We suggest that such a program should commence if fluoride is absent in the drinking water for more than 90 days. Obviously, health units would need additional funds for this supplementary program.

It might be prudent to include guidelines dealing with interruption of the fluoridated water supply, whether this be due to lack of the material (e.g., hydrofluosilicic acid) or due to equipment breakdown. These guidelines could be similar to those sent to all dental directors in a letter dated June 4, 1982, by Dr. K. Ryan, the Senior Dental Consultant to the Ontario Ministry of Health. (Fluoride absent up to 90 days - fluoride absent more than 90 days in the drinking water).

PREVENTIVE DENTISTRY

PART II

DENTAL HEALTH EDUCATION - ORAL HYGIENE INSTRUCTION PROGRAMS

Re p. 35

STANDARD

(1) With respect to oral hygiene instruction in schools, we do provide such instruction, but at present do not offer it seven times within the period, as the guideline (1)(e) requires. This would represent an additional workload.

We have found plaque disclosure (d)(ii) to be a very useful technique. However, it has been our experience that this is a messy procedure and that it has, on occasion, caused concern to the parents of the children involved. In addition, we have had at least one report of a possible allergic reaction to the tablet. Given this, we suggest that one or two children may be used to demonstrate plaque disclosure. Perhaps we will also need to consider the issue of consent.

(2) This makes reference to preschool registration and we strongly support the importance of this early approach. However, it has been our experience that in many schools few parents attend preschool registration, even in the face of quite intensive canvassing from the staff of the schools. Therefore, there may be practical problems in carrying out this program.

Also in (2), we presume that the reference to programs for special groups implies that this should really be a service performed upon demand. We strongly support the concept, but recognize that there may be resource constraints.

We suggest the addition of a Standard (3) as follows: "Ensure that nutrition services be available as required under the nutrition guidelines."

Re p. 36

IMPLEMENTATION

(2) Staffing

It is stated that "the education and instruction activities shall be conducted by appropriately trained dental health educators". As there are 43 health units in the Province, each might have quite different qualification requirements for their dental health

educators. It is advisable to have a Standard setting out basic qualifications and requirements for educational upgrading (e.g., courses offered by the Society of Ontario Public Health Dentists), so that at least a minimum standard level of expertise is present throughout the Province.

PREVENTIVE DENTISTRY

PART III

SCREENING AND REFERRAL PROGRAM INCLUDING DENTAL HEALTH SURVEY

Re p. 38

STANDARD

(1) This is worded in terms of ages, but since our programs are provided to grades rather than ages we believe that the guideline should be worded to reflect school grades. Also, we presently offer programs only up to grade 8 and, therefore, the inclusion of age 15, which is grade 10, would be an additional workload. Is this what the Ministry intended?

It is important to have clarity in the following as referral may impact on child neglect. Standard (3) states: "That where the screening examination indicates either an immediate/acute dental condition, or an urgent dental condition, the public health dentist shall take appropriate action consistent with established professional standards of practise". While there is a definition of "immediate/acute dental condition", there is no such definition or procedure outlined as to what constitutes the action, or sequence of actions, to be taken when such conditions are found. As this has legal implications, the procedure, to have some uniformity, should be articulated. This comment also applies to the topical fluoride program (p.40) in the course of which urgent or acute dental conditions may be noted.

IMPLEMENTATION

Re p. 38

(1) Program Administration

There is reference to providing data on the follow-up (b)(v) of children referred. While we support such follow-up, and it is crucial to the evaluation of a program such as this, it is also a very time-consuming and laborious task, and would again require additional staff. On the other hand, we are currently doing the survey in every grade, and if we were to do it for every other grade as proposed in the guidelines, this would free-up more staff time for following-up referrals, education, and oral hygiene instruction.

PREVENTIVE DENTISTRY

PART V

GERIATRIC PROGRAM

Re p. 42

STANDARD

We already do a certain amount of this program on request, and we support the intent of providing additional services for seniors. The preliminary results of a survey we have conducted in our Eastern Health Area indicate a considerable need for such services, and suggest that some form of dental insurance for seniors may be desirable.

The reference in Standard (2)(b) to identifying prosthetic appliances which we are cleaning will require a technique to enable us to label, mark, or in some other way identify these appliances.

As regulations enacted (or interpreted) by the Royal College of Dental Surgeons stand at present, hygienists are not allowed to perform clinical procedures at "arms-length" on adults, including senior citizens. Hence preventive measures, such as topical fluoride application, scaling, or prophylaxis would have to be performed by a dentist or the latter would have to be on the premises to provide supervision to the hygienist performing such a service. The Department and Ministry should advocate the extension of the principle of "arms-length" supervision of hygienists in relation to clinical procedures to the area of dental public health and institutions (e.g., senior citizens, mentally retarded, etc.). The written prescription of a dentist (after an initial examination) to the hygienist might facilitate such a change in legislation.

NUTRITION

PART I

IDENTIFICATION OF COMMUNITY NUTRITION NEEDS

Re p. 45

STANDARD

(1) We recommend that the phrase "updated biennially" be amended to "updated as appropriate".

NUTRITION

PART II

NUTRITION SERVICES TO BOARD OF HEALTH PROGRAMS

Re p. 47

STANDARD

We recommend the following changes:

(1)(d) and (e) Delete "including dental health" and add "dental health" as a separate program.

(3)(d) and (g) - add: "nutrition assessment".

Add: "(h) Dental Health: Ensure that nutrition services be available as required under the nutrition guidelines."

One of our concerns with the provision of "Nutrition Services to Board of Health Programs" is the extent to which Health Area priorities will permit staff to incorporate a nutrition education component in each of the seven lifecycle programs listed. The implementation of this Standard requires the provision of in-service education to staff in each program area. Based on a theoretical allotment of one-half day per program, three and one-half days from all nursing staff would be needed to provide an annual in-service. It will be expensive to expect this time commitment from Area staff.

NUTRITION

PART III

NUTRITION SERVICES TO THE COMMUNITY

Re p. 50

STANDARD

(1)(d) This proposes a directory of nutrition services in the community. The development (and regular updating) of such a directory for the City is an enormous task and could not be completed with existing staff. We recommend that the guideline referring to the annual updating of the directory be changed to "updated as appropriate".

General Comments

Funding - The guidelines as written could not be implemented with present staff. Is the Ministry willing to provide additional funding? Has a time framework been established for implementing the mandatory programs?

Overall Thrust of the Guidelines - The proposed programs represent a traditional approach to the delivery of public health nutrition services and reinforce the attempt to "be all things to all people". As they are written, their focus is process-oriented, i.e., the emphasis is on activities to be undertaken, rather than changes in knowledge, attitudes or nutritional status.

In addition to the set of three Nutrition Program Services, nutrition is also incorporated into other mandatory programs, i.e., Family Health (maternal and parental, infant, preschool) and Dental Health. Our concern is with the way in which the guidelines for these programs are written. There is no reference to a nutritionist's involvement in developing and implementing the standards. It seems that if standards for the delivery of nutrition services are to be set, the nutritionist's role should be better defined.

"Referral Services

"3.9 The Department aim at eventually limiting direct service for the adult population to the provision of assessment and referral services, and mental health promotion."

This policy directive needs to be re-evaluated now, five years later, although there is still a possibility that we will remain in conflict with the Ministry Guidelines in this area.

OVERALL COMMENTS

Reference is made several times throughout the guidelines to "seeing to it that . . " certain programs are carried out. The implication being that other agencies and people may be too involved to carry out the program of the Board of Health.

It seems to follow that the Department occasionally would have to develop an arms-length responsibility for the carrying out of certain programs. This could involve some subsidy for the community groups. Such purchase of service agreements may become more possible once the increase to 75% Provincial funding is achieved.

DATA COLLECTION

We are very concerned about the increase in the data to be gathered and, in fact, are somewhat puzzled as the the purpose of some of it. This information will be impossible to collect unless a new and improved data collection tool is devised and computer time is available to make the interpretation of the data usable for planning and evaluation of programs.

In reviewing Section 5 of the Health Protection Act, we note that no guidelines are proposed for the collection and analysis of epidemiological data under family health, and that no guidelines are proposed for public health education. Since both of these are mandatory programs within the Act, the Ministry should develop guidelines in these areas as soon as possible. Since these are areas in which this Department has considerable expertise, we would like to be involved in the development of these standards.

FAMILY HEALTH

PART I

MATERNAL & PARENTAL HEALTH SERVICES

Re p. 56

STANDARD

(1)(4) The definition of counselling seems too narrow for application to this service. Surely there should also be teaching and programs available to the high risk pregnant woman.

We agree that early prenatal care is crucial. It allows identification of pregnant women at high risk, and intervention to modify the risk factors, hence improving pregnancy outcome. Furthermore, we recognize the importance of liaison with physicians and agencies/institutions providing services to women of childbearing age, in ensuring that pregnant women obtain early prenatal care. However, we have concerns that despite present liaison efforts, many women still delay in seeking prenatal care until their second or third trimester.

In the preparation of these Guidelines, the Ministry should not forget the vital support role it must play in complementing health unit activities. We suggest that the Ministry of Health consider the following:

(i) instituting a Province-wide mass media campaign (similar to "Health Begins at Home") to promote early prenatal care and the importance of healthy lifestyle in the preconception and prenatal periods.

(ii) implementing, on a pilot basis, an incentive program to encourage women to seek preconception and early prenatal care.

(iii) developing plans with the Ontario Medical Association to ensure liaison and collaboration between physicians and public health departments.

(5)(7) Childbirth education classes are an effective means of reaching most expectant parents. Although we would like to direct our programs to high risk populations, we have found that prenatal classes are not always the best way of meeting their needs. For these populations we suggest separate classes, (i.e., teen classes, classes in other languages), or individual education and

counselling. If we are to provide childbirth education classes through an agreement with another agency, this will necessitate much closer links with these community agencies. Unless such an arrangement is through a purchase of service agreement, we cannot foresee the Board of Health specifying number of hours for instruction, qualification of instructors, content of classes, etc. We would prefer to see the content of classes spelled out, rather than the restrictions on number of attendees, together with number and length of classes. The latter should be left to the discretion of the group and the teacher.

(7)(a) Rather than "role of partner" we recommend this be changed to "role of support person". In many classes the expectant teenager has her mother along as her support person.

(8) There is some confusion regarding this Standard. The Standard states "that a homevisiting service be made available on request". Then (8)(a) states that the service is "to consist of a minimum of one postnatal visit, not later than 4 weeks after birth or after discharge from hospital". If the service is available on request, it seems contradictory to make specifications regarding the service. If "on request" is meant to imply a mutually agreed decision between the nurse and the mother, then this is appropriate. If, however, the implication is that home visits be made only when the client articulates a request for visits, then the quality of the post-partum program in particular will be markedly reduced.

The value of postnatal home visiting is not a well-researched area. However, what little research there is indicates that visits in the first postnatal days following hospital discharge are most helpful. Full-time assignment of public health nurses to obstetrical units of hospitals would facilitate earlier postnatal home visits. Barring that, ways of increasing the usefulness of the "Notification of Birth" form could be explored, i.e., having it sent to health departments earlier; recording other information on it, such as method of feeding, type of birth, presence of complications, etc.

We suggest the addition of a Standard (9) as follows: Ensure that nutrition services be available as required under the nutrition guidelines".

Re p. 57

IMPLEMENTATION

(1) Program Administration

(b)(iii) Present records do not indicate the number of pregnant women and partners attending childbirth education classes by age and parity. Such information would be useful. Perhaps CHARIS could be revised to provide for collection of such data.

FAMILY HEALTH

PART II

FAMILY PLANNING SERVICES

Re p. 59

STANDARD

(2)(a) We are in full agreement with this Standard. However, this target group is frequently unavailable to Departmental staff since we have no authority to ensure that our programs are mandatory in the school. This is an unfortunate dilemma since the school could provide a captive audience to whom accurate information could be provided.

Of even more concern, however, is that reports indicate sexual activity and awareness is beginning at a much younger age, such as 11 years. Abortion and pregnancy statistics will lend support to this. Hence an even earlier contact should be made in the school system.

(6)(b) We recommend that an item "Counselling regarding family planning and education" be included, perhaps prior to point (v).

We recommend the addition of a Standard (7) as follows: "Ensure that the nutrition services be available as required under the nutrition guidelines".

FAMILY HEALTH

PART III

INFANT HEALTH SERVICES

Re p. 63

STANDARD

(1)(4) We recognize the importance of identifying high risk infants, ensuring their referral and follow-up, and providing support to their families. Liaison with physicians, health, and social agencies is one way of ensuring the availability of appropriate care to these infants, but we have two concerns regarding this Standard.

Our first concern deals with confidentiality, i.e., will consent be required to share information between the health departments and physicians, health and social agencies? Secondly, despite current efforts at liaison, some physicians refuse to acknowledge and work with the public health sector. We feel that this problem needs to be addressed at the Ministry level.

The issue of postnatal home visiting has been addressed under "Maternal and Parental Health Services". There is some ambiguity regarding the services to be provided on this home visit. The term "where appropriate" is used in Program Delivery (3)(b)(i) and (ii). It is not clear when assessments are to be done; is it left to the nurse's judgement? This should be clarified.

(5) Presently we have little or no information regarding foster homes in our area. We see this as a mammoth job, not only to decide who is to search out these homes, but to establish contact. This would necessitate liaison with the Ministry of Community and Social Services to develop relevant procedures. This may not be possible within our present staffing situation.

(6) It is a known fact that the truly high risk parent does not attend parenting classes. As previously stated under "Maternal and Parental Health Services", it is often difficult to recruit high risk parents for parent education classes. Other alternatives need to be explored, i.e., provision of incentives for attending; mandatory attendance; individual education and counselling. Similar to childbirth education classes, if parenting classes are to be provided through an agreement with other agencies, it must be a purchase of service agreement or the Board of Health would not be able to control qualifications of instructor, content of classes, etc.

We suggest the addition of a Standard (8) as follows: "Ensure that nutrition services be available as required under the nutrition guidelines".

Re p. 64

IMPLEMENTATION

(3) Program delivery

We recommended earlier the use of the media to promote good parenting, breastfeeding, etc. We feel that the Ministry of Health also has a role to play in this area and suggest that a Province-wide mass media campaign (similar to "Health Begins at Home") to promote this information, be undertaken.

FAMILY HEALTH

PART IV

PRESCHOOL HEALTH SERVICES

Re p. 66

STANDARD

(1) In many situations relationships are excellent but unfortunately there are instances where physicians do not seek out or offer cooperation to the public health nurse. Perhaps some assistance in understanding both the Department of Public Health and the public health nurse is needed through media coverage.

(2) It is not clear at whose request a home visit would be made, i.e., only on parental request or at the request of a physician, day nursery supervisor, etc. This should be clarified in the guideline.

(3)(4) We recognize the need for procedures to identify high risk preschool children. In order to ensure the same quality of care across the Province, should these procedures not be developed at the Ministry level with room for local additions? The guidelines state that those children with impairments shall be referred through the parent to the appropriate consultant. Problems arise when parents do not follow-through on such action. What options are available to ensure follow-up for the child? We recommend that the Ministry address this issue.

(5) The Standard states "That services such as hearing . . . based on need". What is meant by "based on need"? As it stands, this is ambiguous and requires further clarification.

(6) The comments made under "Maternal and Parental Health Services" and "Infant Health Services" regarding the recruitment of high risk parents for classes and the provision of parenting classes through an agreement with other agencies, apply to this section as well.

We recommend the addition of a Standard (8) as follows: "Ensure that nutrition services be available as required under the nutrition guidelines".

Re p. 67

IMPLEMENTATION

(1) Program Administration

(1)(b) This details important information to be collected on preschool health programs. Such information is important for program planning and evaluation. However, the present CHARIS form would have to be revised or a new data collection form would have to be developed to collect the proposed information.

FAMILY HEALTH

PART V

SCHOOL HEALTH SERVICES

Re p. 69

STANDARD

(6)(i) This Standard proposes that hearing screening be conducted at school entry and at grade 1, whereas our current program is for SK, grade 2 and grade 5.

FAMILY HEALTH

PART VI

ADULT HEALTH SERVICES

Re p. 72

STANDARD

(1) While the multidisciplinary approach to lifestyle diseases is the route that many agencies are taking, it may be more appropriate to look at major causes of death and disease and thereby encompass environmental causes as well.

We recommend the addition of a Standard (5) as follows: "Ensure that nutrition services be available as required under the nutrition guidelines".

Re p. 73

(3) Program Delivery

The topics for educational programs are too specific for inclusion in guidelines. A "post coronary care" program (a)(iii) seems inappropriate.

FAMILY HEALTH

PART VII

GERIATRIC HEALTH SERVICES

Re p. 74

STANDARD

(1) This Standard is in conflict with the Departmental, Board of Health and City policy as outlined in Public Health in the 1980's. This policy concentrates on pre-retirement counselling, rather that the health needs assessment and service provision to the elderly. However, note that there appears to be a loop hole, since Standard (1)(a) refers to the needs of the elderly being included "as considered appropriate by the Medical Officer of Health".

In addition, we note in Standard (5) that regular health visits can seemingly be surplanted by "other follow-up procedures arranged in the community".

(5)(b) If monitoring is used in the sense of "follow-up" to the coordination of services, provision of support services, etc., for the elderly at risk, this is acceptable. Each agency would then establish priorities according to the population of its jurisdiction and deploy human resources appropriately. If this is not the interpretation, then the matter should be carefully clarified before the guidelines proceed further since it could be very likely that additional manpower would be required.

We recommend the addition of a Standard (6) as follows: "Ensure that nutrition services be available as required under the nutrition guidelines".

FAMILY HEALTH

PART VIII

COMMUNITY MENTAL HEALTH SERVICES

Re p. 77

STANDARD

Specific mention should be made of:

1. Consultation services to workers from other agencies, relatives of patients and to staff of health units, especially public health nurses, from persons especially trained in mental health.

   The public health nurse is a generalist and s/he, as well as other staff in health units, requires consultation, support and back-up from mental health specialists such as mental health nurses, psychiatrists, psychologists and others.

2. Liaison with psychiatric hospitals and psychiatric units of general hospitals.

3. Staff development and inservice training.

According to Public Health in the 1980's, the philosophy expressed was for the Department to concentrate on primary prevention programs in mental health, while at the same time to gradually ease out of direct services (secondary and tertiary prevention). This would be accomplished by ensuring that the latter services are taken over by other agencies.

Public Health in the 1980's stated:

"Treatment Services

"3.3 At present, the Department provides community mental health treatment services, although such service delivery is neither part of public health's mandate nor specifically funded in its budget. It provides these services largely because no other agency has assumed responsibility for them. While the Department will necessarily continue to provide such services in the short run, it must set a very high priority on lobbying for the establishment and adequate funding of a separate community mental health service network."

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January 6, 1983

TO: ALL MEDICAL OFFICERS OF HEALTH

Dear Doctor:

Re: DRAFT GUIDELINES FOR MANDATORY HEALTH PROGRAMS AND SERVICES

During the past three months, committees composed of representatives from the Ministry and health units have been developing guidelines for mandatory health programs and services. These guidelines are being developed to support the provisions of the proposed Health Protection Act which has recently received second reading in the Legislature. The draft guidelines are now being forwarded to you and your senior staff for review and comment. They are also being circulated to many external interest groups, organizations/associations.

The attached document contains guidelines for Community Sanitation, Control of Communicable Diseases, Preventive Dentistry, Nutrition and Family Health Programs. It includes both:
(i) the Phase I guidelines circulated in 1981 which have now been revised by Ministry staff to conform to the new format: and
(ii) guidelines for the remainder of the mandatory programs which until now were not available and which have been developed by the Committee members as outlined in each report. I would urge reviewers to read the Introduction for a more indepth orientation to the legislative basis for the guidelines and the new guidelines format.

This circulation of the draft to all senior staff of all health units is in recognition of the importance we place on receiving your input during the guidelines development process. To date the guidelines are the work of small committees who are now looking to you for feedback which will be considered in the next revision.

Feb. 18/83

I would appreciate receiving your comments by [redacted] in order that they may be considered when the committees reconvene to finalize the guidelines. Thereafter, the guidelines will be submitted to senior Ministry management for their consideration.

If you have any questions regarding the review process for the guidelines, please contact Catherine Rand, Manager, Public Health Resource Service at 963-2232. If you have questions regarding specific reports, please contact the individual committee chairmen.

Yours very truly,

Barbara Blake

Barbara J. Blake, M.D., D.P.H.
Director
Public Health Branch

CR/mn
cc: Director of Inspection ✓
Director of Nursing
Dental Director
Nutritionist

DRAFT FOR COMMENT

NOT MINISTRY POLICY

DRAFT GUIDELINES

FOR

MANDATORY HEALTH PROGRAMS AND SERVICES

AS PERTAINS TO

THE PROPOSED

HEALTH PROTECTION ACT

December 1982

Public Health Branch

Ontario Ministry of Health

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INTRODUCTION

Mandatory Health Programs and Services

Bill 138, An Act Respecting the Protection of the Health of the Public, outlines mandatory health programs and services which each Board of Health shall provide or ensure are provided to persons residing in the health unit (Section 5 below). It further indicates that the Minister of Health may publish guidelines for the provision of those programs and services (Section 7). The attached draft guidelines have been developed in fulfillment of Section (7) with respect to Section (5).

PART II

HEALTH PROGRAMS AND SERVICES

4. Every board of health, — Duty of board of health

(a) shall provide or ensure the provision of the health programs and services required by this Act and the regulations to the persons who reside in the health unit served by the board; and

(b) shall perform such other functions as are required by or under this or any other Act.

5. Every board of health shall provide or ensure the provision of health programs and services in the following areas: — Mandatory health programs and services

1. Community sanitation, to ensure the maintenance of sanitary conditions and the prevention or elimination of health hazards.

2. Control of communicable diseases, including provision of immunization services to children and adults.

3. Preventive dentistry, including provision of preventive dental services to persons residing in the health unit and provision of dental health education, oral hygiene and fluoride therapy programs to school children.

4. Family health, including,

i. provision of counselling services,

ii. establishment of family planning services,

iii. programs to identify pregnant women who are in high-risk health categories,

iv. provision of health services to infants, pregnant women in high-risk health categories and the elderly,

v. provision of preschool and school health services,

vi. collection and analysis of epidemiological data.

5. Home care services that are insured services under the *Health Insurance Act*, including services to the acutely ill and the chronically ill. — R.S.O. 1980, c. 197

6. Nutrition, including provision of consulting and educational services and identification of nutrition services needed by persons residing in the health unit served by the board of health.

7. Public health education, including education in the prevention and control of life-style diseases.

8. Such additional health programs and services as are prescribed by the regulations.

School pupils

6.—(1) Every board of health shall provide such of the health programs and services as are prescribed by the regulations for the purposes of this section to the pupils attending schools within the health unit served by the board of health.

Consent of school

(2) Subsection (1) does not apply in respect of pupils attending a school unless the person or organization that operates the school has agreed to the provision of the particular health program or service to the pupils attending the school.

Application of subs. (1)

(3) Subsection (1) applies only in respect of the classifications of pupils prescribed by the regulations in respect of a health program or service.

Prohibition

(4) Where a board of health is required by this Act or the regulations to provide or ensure the provision of a health program or service, no person or organization that operates a school in the health unit served by the board of health shall provide or ensure the provision of the health program or service to a pupil in the school without the approval of the medical officer of health for the health unit.

Guidelines

7—(1) The Minister may publish guidelines for the provision of mandatory health programs and services and every board of health shall comply with the published guidelines.

Idem

(2) Guidelines shall be transmitted to each board of health and shall be available for public inspection in the Ministry.

Application of R.S.O. 1980, c. 446

(3) A guideline is not a regulation within the meaning of the *Regulations Act*.

Conflict

(4) In the event of conflict between a regulation and a guideline, the regulation prevails.

Extent of programs and services

8. A board of health is not required by this Part to provide or ensure the provision of a mandatory health program or service referred to in this Part except to the extent and under the conditions prescribed by the regulations and the guidelines.

Optional health programs and services

9. A board of health may provide any other health program or service in any area in the health unit served by the board of health if,

(a) the board of health is of the opinion that the health program or service is necessary or desirable, having regard to the needs of persons in the area; and

(b) the councils of the municipalities in the area approve of the provision of the health program or service.

Format for Guidelines for Health Programs and Services

Guidelines for the services to be implemented under Phase I were developed and circulated to health units some time ago. The attached document contains both those original guidelines (revised to conform with a new format and indicated with an asterisk on the cover page for each program) and new guidelines for the remainder of the mandatory programs which until now have not been available.

Reviewers will note that the draft guidelines differ in format and wording from most guidelines produced by the Public Health Branch. This has been done not only to reflect the legal nature of the documents, but also to facilitate interpretation and understanding by the public.

The STANDARD section indicates what service the Board of Health shall ensure is provided, either through its own staff or other community resources. The IMPLEMENTATION section outlines how the service will be carried out in terms of Program Administration, Staffing and Program Delivery.

The IMPLEMENTATION section contains a mix of specificity and flexibility. For example, the Program Administration sub-section details the records to be maintained and requires the preparation of an annual operational plan. Flexibility frequently appears in the Program Delivery sub-section where alternatives, within certain limits, are given as to how the STANDARD might be met. In short, the guidelines are attempting to provide a degree of specificity which will facilitate interpretation and monitoring of the mandatory programs while at the same time being flexible enough to respond to local situations.

Additional Explanatory Notes

Some additional explanations that will assist in the review of the guidelines are as follows:

- Reviewers will note that Section (6) of the Bill states that services provided to school pupils will be provided through regulations (not via guidelines). The regulations have yet to be drafted. However, in order to provide some insight as to the content of school health programs, details have been included in the guidelines format herein. These guidelines will be used to draft the regulations at a later date.

- Please note when reviewing the guidelines that the standards have been written to reinforce and amplify the statutory responsibility provided to the Board and the Medical Officer of Health under the proposed Health Protection Act (Bill 138). Where such statutory responsibility is already provided in the Bill, it has not been repeated in the Guidelines. For example, in Hospital Communicable Disease Control guidelines, it is not necessary to state that the Board shall become actively involved in the investigation and control of outbreaks of designated diseases in the health unit which may have originated in a hospital. This responsibilty is already in the Bill.

- Operational plan appears in the guidelines for all programs. It is here defined as an outline of the activities which the Board of Health will undertake to ensure the effective and efficient completion of its objectives within a defined planning period. Its essential components include:

  - objectives which are desirable, achievable, measurable, ends-oriented and specific in terms of the "Standards" in the guidelines;

- activities that will be undertaken to achieve those objectives;

- the establishment of indicators, expressed if possible in quantitative terms, against which progress toward achievment of stated objectives may be measured.

December 1982

DRAFT FOR COMMENT

NOT MINISTRY POLICY

DRAFT GUIDELINES

FOR

COMMUNITY SANITATION PROGRAM

- Inspection of Premises*
- Training of Food Premises Personnel
- Demand Service*

Committee Members For Development of Guidelines for Training of Food Premises Personnel

- Don Porter, Senior Consultant, Public Health Inspection, Public Health Branch, Ministry of Health (Committee Chairman)
- Phil Barton, Director of Inspection, Ottawa-Carleton Health Unit
- Roy Hillis, Director of Inspection, Wellington-Dufferin-Guelph Health Unit (Association of Supervisors of Public Health Inspection)
- Peter Moccio, Senior, Public Health Inspection Service, Kingston, Frontenac, and Lennox and Addington Health Unit (Canadian Institute of Public Health Inspection-Ontario Branch Inc.)
- Dr. William MacPherson, Medical Officer of Health, Grey-Owen Sound Health Unit (Society of Medical Officers of Health)

* Phase I Guidelines have been revised by Ministry staff to conform with new guideline format.

GUIDELINES FOR THE PROVISON OF MANDATORY PROGRAMS

UNDER THE PROVISION OF

THE HEALTH PROTECTION ACT — SECTION 7

COMMUNITY SANITATION

PART I

INSPECTION OF PREMISES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT THE PREMISES IDENTIFIED IN SCHEDULE 1 ARE INSPECTED IN ACCORDANCE WITH THE FREQUENCIES STATED THEREIN.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual Operational Plan pertaining to the Standard.

(b) Annual records shall be maintained indicating the following:

(i) the number of premises that are inspected,

(ii) the type of premises,

(iii) total number of inspections carried out on each premises,

(iv) the number of orders made under the Health Protection Act and the disposition thereof,

(v) the number of charges laid as a result of non compliance with orders under the Provincial Offences Act,

(vi) the number of closure orders issued and the disposition thereof,

(vii) the number of appeals commenced and the disposition thereof.

(c) A written report shall be made by the inspectors following each inspection carried out in compliance with this Guideline. The report shall be in a standard format approved by the Medical Officer of Health.

(2) Staffing

The inspections referred to in the Standard shall be carried out by public health inspectors under the direction of the senior ranking public health inspector, with other health care professionals or specialists being employed as considered appropriate by the Medical Officer of Health.

(3) Program Delivery

(a) Under item (1) of the Standard, the inspections will be carried out in accordance with accepted standards of practice as developed or sanctioned by the Advisory Committee on Public Health Inspection Practice to the Public Health Branch. Such Standards will be designed to ensure compliance with the Health Protection Act and Regulations therein.

The Phase I Guidelines have been revised to reflect the new guideline format. The frequency of inspection for Banquet Facilities, Butcher Shops and Institutional Food Services have been changed. Tattoo Parlours and Supermarkets have been added.

PROPOSED MINIMUM SERVICE LEVEL

FIXED PREMISES INSPECTION

	Establishment	Frequency
	DRINKING WATER	
*	Communal Water Supplies and Facilities	4 per year
	Water Haulage Facilities	1 " "
	GENERAL SANITATION	
	Airport/Bus Terminal	1 per year
	Arena	1 " "
	Barber Shop	1 " "
	Beauty Parlour	1 " "
	Billiard Pool/Hall/Arcade	1 " "
	Bowling Alley	1 " "
	Funeral Home	1 " "
	Golf Course/Curling Rink	1 " "
	Health Club	2 " "
	Hotel/Motel	1 " "
	Kennel	1 " "
	Laundromat/Laundry	1 " "
	Marina	1 " "
	Mobile Home Park - Permanent	1 " "
	Pet Shop	1 " "
	Public Washrooms	2 " "
	Rendering Plants, Other Offensive Trades	1 " "
	Theatre	1 " "

* Note Definitions - Page 7

	Establishment	Frequency
**	Tattoo Parlours	1 per year
	HOUSING	
	Placarded Premises	1 " "
	Migrant Farm Worker Housing	1 " "
	Transient Labour Camps	1 " "
	Boarding Homes	2 " "
	INSTITUTIONAL SANTIATION	
*	Children's Residential Care Facility	1 per year
	Correctional Institution	2 " "
*	Day Nurseries	2 " "
*	Homes for the Aged	2 " "
*	Homes for Special Care	1 " "
	Hospitals	1 " "
	Psychiatric Hospitals	2 " "
	Schools	2 " "
*	Special Residential Facilities	1 " "
	RECREATIONAL SANITATION	
	Bathing Beach - Public	1 per week (during bathing season)
	Farm Vacation Home	1 per year
	Outpost Camp	1 " "
	Play Park, Race Track, Fair Ground	1 " "

** New Category added
* Note Definitions - Page 7

	Establishment	Frequency
	Riding Stable	1 per year
	Summer Camp	2 " "
	Swimming Pool - Public	12 " " (monthly where seasonal)
	Travel, Trailer Park, Campground, Picnic Areas	2 " "
	Tourist Establishment	1 " "
	Wading Pool - Public	1 per month (seasonal (3 per year)
	Bakery	4 per year
	Bake Shop	4 " "
*	Banquet Facilities	4 " "
	Beverage Room	2 " "
	Bottling Plant	2 " "
*	Butcher Shop	4 " "
	Cafeteria	6 " "
	Cannery	2 " "
	Caterer (Food)	4 " "
	Cheese Factory	6 " "
	Cocktail Bar	2 " "
	Commissary	4 " "
	Dining Room (i.e. Hotel, etc.)	6 " "
	Drive-In	3 " "
	Food Depot	2 " "

* Note increase in minimum inspection frequency

	Establishment	Frequency
	Food Processing Plant	2 per year
	Food Store (Convenience, Variety)	2 " "
	Food Vending Facilities	1 " "
	Ice Cream Plant	6 " "
	Ice Cream Stand - Soft	4 " "
	Ice Cream Stand - Hard	1 " "
	Ice Manufacturing Plant	2 " "
	Industrial Camp	4 " "
*	Institutional Food Service (i.e. Hospitals, Homes for the Aged)	6 " "
	Locker Plant	2 " "
	Milk Depot	2 " "
	Milk Pasteurization Plant	6 " "
	Milk Products Plant	6 " "
	Mobile Food Premises	1 " "
	Mobile Food Preparation Vehicle	2 " "
	Private Club	2 " "
	Refreshment Stand	1 " "
	Restaurant	6 " "
	Serving Kitchen	3 " "
	Slaughterhouse & Meat Processing Plant	2 " "
**	Supermarkets (Bulk Food Merchandising)	4 " "
	Take Out (Food)	3 " "

* Note increase in minimum inspection frequency
** New category added

DEFINITIONS

Communal Water Supplies and Facilities
(Small Communal water supplies not actively controlled by Ministry of the Environment)
(Ontario Water Resources Act - 1980 CH. 361) Sec. 23(9)

Children's Residential Care Facility
(as defined in the Children's Residential Services Act, 1980 CH. 71 Sec. 1(c)

Day Nurseries
(as defined in Day Nurseries Act 1980 CH. 111 Sec. 1(d)

Homes for the Aged
(as defined in Homes for the Aged and Rest Homes Act: 1980 CH. 203 Sec. 1(c)
Charitable Institutions Act 1980 CH. 64 Sec. 1(c)

Homes for Special Care
(as defined in Homes for Special Care Act 1980 CH. 202 Sec. 1(a)

PART II

TRAINING OF FOOD PREMISES PERSONNEL

STANDARD

THAT THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT TRAINING BE MADE AVAILABLE TO FOOD PREMISES PERSONNEL.

(2) THAT A STRATEGY BE DEVELOPED TO PROMOTE THE VALUE OF ATTENDANCE AT TRAINING COURSES.

(3) THAT AN INFORMATION AND ADVISORY SERVICE BE MADE AVAILABLE TO PEOPLE AND AGENCIES PROVIDING TRAINING.

(4) THAT THE CONTENT OF TRAINING COURSES INCLUDE, BUT NOT TO BE LIMITED TO THE FOLLOWING TOPICS:

(a) THE ROLE OF LOCAL BOARD OF HEALTH.

(b) PUBLIC HEALTH LAW.

(c) BASIC MICROBIOLOGY.

(d) HOUSEKEEPING AND GENERAL MAINTENANCE.

(e) PERSONAL HYGIENE.

(f) EQUIPMENT.

(g) DISHWASHING.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Annual records shall be maintained indicating the following:

(i) The total number of courses conducted; the number of people in attendance; number of persons completing the course; the average number of persons attending each course.

(ii) A record of each person's attendance and an indication of these persons' positions, i.e. owner, cook, waiter, butcher, etc.

(iii) Records of the number of advisory consultations; the numbers of people and/or agencies consulted; and the time involved.

(iv) Records of the total amount of staff time devoted to food premises personnel training.

(2) Staffing

The services and activities referred to in the Standard shall be carried out by public health inspectors under the direction of the senior ranking public health inspector or by other health care professionals and specialists as considered appropriate by the Medical Officer of Health.

(3) Program Delivery

(a) Under item (1) of the Standard, it is recommended that priority for training be given to the following groups:

(i) Management personnel in high risk premises.

(ii) Food premises personnel employed in all categories in high risk premises.

(iii) Management personnel in low risk premises.

(iv) Food premises personnel employed in all categories in low risk premises.

(b) The intent of item (1) of the Standard may be met through:

(i) entering into an agreement with a community college, university, or other teaching facility to provide training courses in accordance with, but not limited to, the minimum requirements of this guideline,

(ii) the provision of individual topics which can lead to a full training course upon request by the owner/operator of a food premises at a mutually convenient time,

(iii) the provision of training courses of appropriate duration which will be offered to food premises personnel at least once per year,

(iv) the inclusion of an education component in every routine public health inspection of a food premises.

(c) The intent of item (2) of the Standard may be met through the provision of a written "certificate of recognition" to those personnel who have successfully completed a training course.

The certificate shall contain the following information:

(i) Date of course completion.

(ii) Course duration, title, and content.

(iii) Signature of instructor or Medical Officer of Health.

(iv) Name of person completing the course.

(d) The intent of item (2) of the Standard may also be met through media promotion, newsletters, public displays and pamphlets.

(e) The intent of item (3) of the Standard may be met through establishing a regular liaison with a broad spectrum of allied agencies, organizations, groups and individuals in order to offer professional consultation, resource material and personnel.

(f) Under item (4) of the Standard, approved resource materials and equipment will be made available to the staff to ensure proper implementation of training courses.

(g) Under item (4) of the Standard, a means of evaluating the content of training courses* will be developed and implemented (i.e. course critique's questionnaire, an improvement in the standards of operation in food premises).

*A brief description of the Training Course content is given in Appendix "A".

APPENDIX A

TRAINING COURSE CONTENT

COURSE OUTLINE - TOPICS

1.	The Role of the Local Official Health Agency.	a) The Role of the Public Health Inspector
		b) Public Health Terminology - i.e. definition as prescribed in Section I of the Food Premises Regulations
2.	Public Health Law	a) Health Protection Act
		b) Food Premises Regulation
		c) Other Regulations and Standards
3.	Basic Microbiology	a) Time/Temperature Relationships
		b) Types of Food Poisoning
		c) Direct and Indirect Transmission of Bacteria
4.	Housekeeping and General Maintenance	a) Construction Standards (including lighting and ventilation)
		b) Pest Control
		c) Garbage Storage and Removal
		d) Storage of Non-food Products
		e) Work Surface Maintenance
		f) Washroom Facilities

5. Personal Hygiene	a)	Handwashing and Provision of Handwash Facilities
	b)	Provision of Clean Outer Garments
	c)	Exclusion of Personnel from Work
	d)	Provision of Proper Lockers, Dressing Rooms, etc.
6. Equipment	a)	Water Supply
	b)	Refrigeration
	c)	Storage Space
	d)	Cleaning and Disinfecting
	e)	Construction of Equipment and Utensils
7. Dishwashing	a)	Manual Dishwashing
	b)	Mechancal Dishwashing
	c)	Optional Methods

DEFINITIONS

1. **Food premises personnel** - all persons employed in premises as defined in Regulation 840/80, Section (1), Part d Sub-sections (1) and (11)

2. **High risk Premises** - A premises identified by Health Unit personnel as being in a high priority grouping for the provision of Food Premises Personnel Training. Consideration is to be given to the nature of the operation and the degree to which the premises is in compliance with the appropriate legislation. Such premises would normally have a higher than average inspection frequency.

3. **Low risk Premises** - A premises identified by Health Unit personnel as being in a low priority grouping for the provision of Food Premises Personnel Training. Consideration is to be given to the nature of the operation and the degree to which the premises is in compliance with the appropriate legislation. Such premises would normally have a lower than average inspection frequency.

4. **Food premises** - As defined in Regulation 840/80, Section I, Part g.

PART III

DEMAND SERVICE

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT A RESPONSE BE MADE TO ANY COMMUNITY SANITATION COMPLAINTS AND REQUESTS FOR SERVICE WITHIN TWO WORKING DAYS FROM THE TIME OF RECEIPT.

(2) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO:

(a) ASSESS THE INCOMING COMPLAINTS AND REQUESTS FOR SERVICE.

(b) DETERMINE THE APPROPRIATE ACTION TO BE TAKEN.

(c) RANK INVESTIGATIONS IN ORDER OF PRIORITY.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Annual records shall be maintained indicating the following:

(i) nature of request,

(ii) date received,

(iii) date of response and investigation,

(iv) action taken and results,

(v) date completed and final disposition.

(c) A report of the results shall be sent to the complainant (Health Protection Act - Section 11).

(2) Staffing

The services and activities referred to in the Standard shall be carried out by the Medical Officer of Health where necessary and/or public health inspectors. Additional health care professionals or other considered specialists shall be employed where appropriate by the Medical Officer of Health.

(3) Program Delivery

(a) Under item (1) of the Standard it is not intended that complaints and request for service will necessarily be resolved within two working days. However, it is expected that staff of the Board will initiate and investigate within the time period. Such action may include:

(i) Contacting the complainant for further information and to provide advice.

(ii) Consulting with other provincial ministries who might be involved.

(b) Under item (2) of the Standard resource material and equipment approved by the Medical Officer of Health may be made available to the staff.

December 1982

DRAFT FOR COMMENT

NOT MINISTRY POLICY

DRAFT GUIDELINES

FOR

CONTROL OF COMMUNICABLE DISEASE PROGRAM

- Hospital Communicable Disease Control
- Immunization*

Committee Members

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- Dr. William Page, Medical Officer of Health, Brant County Health Unit (Society of Medical Officers of Health)
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* Phase I Guidelines distributed in 1981 have been revised to conform with new format.

GUIDELINES FOR THE PROVISION OF MANDATORY PROGRAMS

UNDER THE PROVISION OF

THE HEALTH PROTECTION ACT

COMMUNICABLE DISEASE CONTROL

PART I

HOSPITAL COMMUNICABLE DISEASE CONTROL

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT CONSULTATION IS PROVIDED TO HOSPITALS ON COMMUNICABLE DISEASE CONTROL WHEN REQUESTED.

(2) THAT, IN ACCORDANCE WITH HOSPITAL BYLAWS, REPRESENTATION IS PROVIDED ON INFECTION CONTROL COMMITTEES.

(3) THAT INSPECTIONS ARE MADE IN ACCORDANCE WITH THE GUIDELINES ON COMMUNITY SANITATION AS THEY RELATE TO THE INSPECTION OF PREMISES.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) It is recommended that the operational plan developed in accordance with the guideline reflect not only the activities associated with items (1) and (3) of the Standard, but also the statutory responsibilities of the Medical Officer of Health relating to the investigation and control of communicable diseases contained in Part IV of the Health Protection Act as they apply to hospitals.

(c) Records shall be maintained indicating the following:

(i) the number of hospitals in the health unit,

(ii) the hospitals which have an Infection Control Committee,

(iii) the committees on which the Board has a representative,

(iv) a summary of any consultations which were provided to hospitals, such as outbreak control, in-service education etc.

(2) Staffing

(i) The activities associated with item (1) of the Standard shall be carried out under the direction of the Medical Officer of Health.

(ii) Representation on the Infection Control Committees shall be by the Medical Officer of Health or his designate.

(iii) The inspections under item (3) of the Standard shall be carried out by a public health inspector or other staff as considered appropriate by the Medical Officer of Health.

(3) Program Delivery

(a) The Board, through its staff, shall develop a formal liaison with hospitals in the health unit.

(b) Board staff shall provide appropriate epidemiological information to hospitals routinely and on request.

(c) While it is recognized that, under the Health Protection Act, the Medical Officer of Health has the responsibility for the investigation and control of communicable diseases anywhere in the Health Unit, in practice the hospital will assume responsibility for the investigation of those non designated communicable diseases occurring in and limited to the hospital.

PART II

IMMUNIZATION

SECTION A

GENERAL

STANDARD

THE BOARD OF HEALTH SHALL:

(1) ENSURE THE AVAILABILITY OF IMMUNIZATION SERVICES TO ALL PERSONS RESIDING IN THE HEALTH UNIT. SUCH SERVICES TO INCLUDE BUT NOT BE LIMITED TO:

(a) THE PROVISION OF INFORMATION ON VACCINES AVAILABLE THROUGH THE MINISTRY OF HEALTH.

(b) THE ADMINISTRATION OF SUCH VACCINES.

(2) OPERATE AS MANY IMMUNIZATION CLINICS AS MAY BE NECESSARY TO ENSURE COMPLIANCE WITH THIS GUIDELINE.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) number of doses by vaccine distributed to the Board of Health,

(ii) number of doses by vaccine distributed by the Board of Health to private physicians.

(iii) number of doses by vaccine administered by staff of the Board of Health,

(iv) number of clinics held,

(v) number of persons attending each clinic,

(vi) staff time required to provide immunization services required by this Guideline.

(vii) number of cases of vaccine preventable disease reported by:

. Age

- Sex
- Immunization Status
- Location

(viii) An immunization record of each person given immunization indicating:

- Date of Immunization
- Vaccine
- Details of any adverse reaction

(2) Staffing

The immunization services required by the Standard shall be carried out under the direction of the Medical Officer of Health.

Administration of the vaccine shall be by qualified staff designated for that purpose. These may be persons employed by the Board of Health and/or health professionals practising in the community.

(3) Program Delivery

(a) Staff shall be provided with current guidelines on immunization procedures and practices.

(b) The immunization services envisaged in the Standard shall be available to all persons residing in the health unit including those persons residing in institutions.

(c) (i) Where immunization is provided by board of health staff, the persons who are immunized shall be given a record of the immunization on the official Ontario Immunization Record Card. Staff will be responsible for updating these cards as necessary.

(ii) Notwithstanding (i) above, all persons should be encouraged to maintain their own immunization record.

(d) The Medical Officer of Health shall assume overall responsibility for the adminstration of vaccines during serious outbreaks.

SECTION B

IMMUNIZATION OF SCHOOL CHILDREN

STANDARD

THE BOARD OF HEALTH SHALL:

(1) DEVELOP AND IMPLEMENT PROCEDURES FOR ASSESSING THE IMMUNIZATION STATUS OF CHILDREN ENTERING SCHOOL FOR THE FIRST TIME IN ONTARIO.

(2) OFFER AND PROVIDE, WHERE CONSENT IS GIVEN, THE PRESCRIBED PROGRAM OF IMMUNIZATION IN RESPECT OF DESIGNATED DISEASES UNDER THE IMMUNIZATION OF SCHOOL PUPILS ACT, TO ALL CHILDREN ENTERING SCHOOL FOR THE FIRST TIME AND TO THOSE CHILDREN ATTENDING SCHOOL WHO MAY NOT HAVE BEEN IMMUNIZED OR WHO REQUIRE A BOOSTER.

(3) IN ADDITION TO THE PROGRAM OF IMMUNIZATION OFFERED UNDER SUB (2), VACCINATION AGAINST PERTUSSIS SHALL ALSO BE AVAILABLE TO THOSE CLASSES OF SCHOOL CHILDREN IDENTIFIED THEREIN AS RECOMMENDED IN THE MINISTRY OF HEALTH SCHEDULE.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) Total school population.

(ii) Number of children enrolled in school for the first time in Ontario - private, public or separate, elementary or secondary.

(iii) Number of school entrants assessed and the results thereof, including the percentage of children assessed who were adequately immunized before and after follow-up.

(iv) Number of school entrants needing, and the number offered immunization.

(v) Number of school entrants receiving immunization.

(vi) Number of school entrants refusing immunization.

(2) Staffing

The immunization services required by the Standard shall be carried out under the direction of the Medical Officer of Health.

Administration of the vaccine shall be by qualified staff designated for that purpose. These may be persons employed by the Board and/or health professionals practising in the community.

(3) Program Delivery

(a) Immunization assessment information may be collected by board staff through personal interview or questionnaire.

(b) Children other than those entering school for the first time will be offered immunization as determined by the Medical Officer of Health.

(c) Those parents who do not respond to the initial offer of immunization and those parents who consent to immunization, but do not keep their appointments shall be followed up with a view to maximising compliance with the immunization program.

(d) It is recommended that:

(i) Assessments be completed within two months of a child's entering school for the first time.

(ii) Immunization updating be completed within one year of the initial assessment.

(e) The services specified in the Standard shall also be available to children not in schools covered by the Immunization of School Pupils Act such as children receiving home instruction and those children living in care and treatment institutions.

Note: This program will be integrated with the Immunization of School Pupils Act 1982.

SECTION C

IMMUNIZATION TO CHILDREN IN LICENSED DAY NURSERIES

STANDARD

THE BOARD OF HEALTH SHALL:

(1) DEVELOP AND IMPLEMENT PROCEDURES FOR ASSESSING THE IMMUNIZATION STATUS OF CHILDREN ENTERING LICENSED DAY NURSERIES FOR THE FIRST TIME.

(2) (i) OFFER AND PROVIDE, WHERE CONSENT IS GIVEN A PRESCRIBED PROGRAM OF IMMUNIZATION SIMILAR TO THAT SPECIFIED WITH RESPECT TO DESIGNATED DISEASES UNDER THE IMMUNIZATION OF SCHOOL PUPILS ACT, TO ALL CHILDREN ENTERING LICENSED DAY NURSERIES FOR THE FIRST TIME IN ONTARIO.

(ii) IN ADDITION TO THE PROGRAM SPECIFIED UNDER SUB (i), CHILDREN ENTERING LICENSED DAY NURSERIES FOR THE FIRST TIME SHALL BE OFFERED VACCINATION AGAINST PERTUSSIS AND PROVIDED VACCINATION WHERE CONSENT IS GIVEN.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) The number of children entering day nurseries for the first time.

(ii) The number of children entering day nurseries who have been assessed; and the results thereof, including percentage of children assessed who are adequately immunized before and after follow-up.

(iii) The number of children needing immunization.

(iv) The number of children offered immunization.

(v) The number of children to whom immunization was provided.

(vi) The number of children who refused immunization.

(2) Staffing

The immunization services required by the Standard shall be carried out under the direction of the Medical Officer of Health.

Administration of the vaccine shall be by qualified staff designated for that purpose. These may be persons employed by the Board and/or health professionals practising in the community.

(3) Program Delivery

(a) Immunization assessment information may be carried out by Board staff through interview or by questionnaire.

(b) The immunization would be initiated before attendance at the day nursery and up-dated according to the recommended Ministry of Health schedule.

SECTION D

PROMOTION OF IMMUNIZATION

STANDARD

THE BOARD OF HEALTH SHALL:

(1) PROVIDE AN ONGOING PROGRAM FOR THE PROMOTION OF IMMUNIZATION WITHIN THE HEALTH UNIT.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained describing any external promotional activities initiated or co-ordinated by health agency staff.

(2) Staffing

Promotion of immunization shall be carried out under the direction of the Medical Officer of Health by anyone who has skills in education and promotion.

(3) Program Delivery

(a) The Medical Officer of Health shall be responsible for the planning and co-ordination of immunization promotion in the health unit.

(b) Promotional programs shall be developed and carried out, making use of all available services and skills including board staff and the community.

(c) Promotional activities shall make use of whatever resources are available such as newspapers, local radio stations, television, etc.

(d) Additional promotional activity should be based upon specific acceptance levels for immunization and the incidence of disease. Local needs should be identified and promotion shall be directed to meet those particular needs.

(e) Routine contact between Board of Health staff and health professionals and clients, shall be used to promote immunization.

December 1982

DRAFT FOR COMMENT

NOT MINISTRY POLICY

DRAFT GUIDELINES

FOR

PREVENTIVE DENTISTRY PROGRAM

- Fluoride Program*
- Dental Health Education - Oral Hygiene Instruction*
- Screening and Referral Program Including Dental Health Survey
- Topical Fluoride
- Geriatrics

Committee Members for Development of Guidelines for latter three programs listed above:

- Dr. Ken Ryan, Senior Dental Consultant, Public Health Branch, Ministry of Health
- Dr. Terry Hicks, Dental Director, Sudbury, North Bay, Timiskaming, Muskoka-Parry Sound, Algoma Health Unit.
- Dr. Shivo Tandan, Dental Director, Hamilton-Wentworth Health Unit
- Dr. Jim Shosenberg, Dental Director, Scarborough Health Department and Peterborough City-County Health Unit
- Dr. Marguerite Archibald, Medical Officer of Health, North York Health Department (Society of Medical Officers of Health)

* Phase I Guidelines have been revised by Ministry staff to conform with new format. As well, the service originally called Preschool Registration has now been included as one of the "special groups" in Dental Health Education - Oral Hygiene Instruction.

GUIDELINES FOR THE PROVISION OF MANDATORY PROGRAMS

UNDER THE PROVISION OF

THE HEALTH PROTECTION ACT -- SECTION 7

PREVENTIVE DENTISTRY

PART I

FLUORIDE PROGRAM

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) (a) THAT THE FLUORIDE LEVEL IN WATER IN FLUORIDATED COMMUNITIES BE MONITORED WITH A VIEW TO MAINTAINING AN OPTIMUM LEVEL OF 1.2 ppm.

(b) THAT WHERE THE RESULTS OF SUCH MONITORING INDICATES A FLUORIDE LEVEL OTHER THAN 1.2 ppm, THE APPROPRIATE AUTHORITIES SHALL BE NOTIFIED IN ORDER THAT ANY NECESSARY ACTION MAY BE TAKEN.

(2) THAT WATER FLUORIDATION BE PROMOTED IN COMMUNITIES WHERE THE NATURAL FLUORIDE LEVEL IS BELOW 0.7 ppm.

(3) THAT IN COMMUNITIES WHERE THE LEVEL OF FLUORIDE IN THE WATER SYSTEM(S) IS BELOW 0.7 ppm, A FLUORIDE PROGRAM FOR ALL ELEMENTARY SCHOOL CHILDREN SHALL BE DEVELOPED AND PROMOTED. THIS PROGRAM SHALL BE OFFERED TO ALL CHILDREN IN GRADES K - 8 WITH THE CONCURRENCE OF THE LOCAL SCHOOL BOARD(S), AND SHALL CONSIST OF EITHER A SCHOOL FLUORIDE MOUTHRINSE PROGRAM OR FLUORIDE SUPPLEMENTS.

(4) THAT A PROGRAM OF FLUORIDE SUPPLEMENTS BE MADE AVAILABLE IN COMMUNITIES WHERE THE LEVEL OF FLUORIDE IN WATER SYSTEM(S) IS BELOW 0.7 ppm.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained according to the current guidelines of the Royal College of Dental Surgeons of Ontario (attached as Appendix 1).

(2) Staffing

The fluoride program shall be carried out under the direction of a qualified public health dentist.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met if fluoride levels are monitored monthly.

(b) The intent of item (2) may be met through:

(i) promotion of water fluoridation through such measures as the media, displays, presentations to community groups...

(ii) the testing of water in non-fluoridated areas on request.

(c) (i) Under item (3) and (4) of the Standard both the Fluoride Mouthrinse Program and the Fluoride Supplement Program shall be carrid out in accordance with accepted standards of practise.

(ii) The Fluoride Mouthrinse Program may be monitored and supervised by appropriate staff such as teachers or volunteers.

(iii) The use of supplements shall be promoted in non-fluoridate areas for infants and children up to age 13 through the family physician, paediatrician, the dental profession and the community.

(iv) A school fluoride supplement program may be used as an alternative to a fluoride mouthrinse program.

(d) To achieve concurrence for dental programs in the school system, regular liaison with appropriate local school officials shall be established and maintained.

APPENDIX I

THE ROYAL COLLEGE OF DENTAL SURGEONS OF ONTARIO

GUIDELINES

FLUORIDE RINSE PROGRAM

1. Fluorides are referred to in Schedules C and A, established by the Regulations for the purpose of Part VI of the Act. (Pharmacy).

2. The following Sections of the Regulation apply to members of the College dispensing fluoride for a mouth rinse program:

   Section 39
   Section 41
   Section 42 (since "sell" includes offer to sell, dispense, distribute, give away and supply)
   Section 46, and
   Section 47.

3. Accurate records of purchases and use of the fluoride should be kept;

4. Consent forms would be required for each participant (updated yearly or blanket consent, i.e. grades Kindergarten to 8);

5. Accurate records should be kept regarding the dates when the topical rinses are given and to whom;

6. Proper security is used for the unmixed and mixed solutions;

7. Only authorized personnel have access to the solutions and any unused material be disposed of;

8. Personnel administering the fluoride rinse program work under the direction or supervision of the Dental Director. Therefore, these personnel are insured under the Malpractice Insurance included with the licence fee;

9. Proper labelling as to contents of the containers and dangers of misuse of the solutions appear on each container (i.e. what to do if an excess amount is ingested);

10. All records pertaining to purchasing, dispensing and distribution of fluoride be kept for 10 years.

PART II

DENTAL HEALTH EDUCATION - ORAL HYGIENE INSTRUCTION PROGRAMS

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT A DENTAL HEALTH EDUCATION AND ORAL HYGIENE INSTRUCTION PROGRAM BE DEVELOPED AND, WITH THE CONCURRENCE OF THE LOCAL SCHOOL BOARD, OFFERED TO ALL ELEMENTARY CHILDREN IN GRADES KINDERGARTEN TO GRADE 8.

(a) ALL LESSONS IN BOTH PROGRAMS SHALL BE DEVELOPED WITH AGE SPECIFIC CONTENT.

(b) THE CONTENT OF THE DENTAL HEALTH EDUCATION PROGRAM SHALL INCLUDE BUT NOT BE LIMITED TO:

(i) NUTRITION INFORMATION.

(ii) INFORMATION ON THE IMPORTANCE OF GOOD DENTAL HABITS SUCH AS REGULAR DENTAL VISITS.

(c) IN ADDITION TO THE ABOVE, THE DENTAL HEALTH EDUCATION PROGRAM SHALL CONSIST OF A MINIMUM OF 30 MINUTES OF INSTRUCTION IN EACH SCHOOL YEAR FOR EACH GRADE K - 8.

(d) THE CONTENT OF THE ORAL HYGIENE INSTRUCTION PROGRAM SHALL INCLUDE BUT NOT BE LIMITED TO:

(i) TOOTHBRUSHING.

(ii) PLAQUE DISCLOSING.

(iii) FLOSSING.

(e) THE FREQUENCY AND LENGTH OF ORAL HYGIENE INSTRUCTION SESSIONS SHALL BE AT THE DISCRETION OF THE PUBLIC HEALTH DENTIST WITH A MINIMUM NUMBER OF SEVEN SESSIONS BETWEEN GRADE KINDERGARTEN TO 8.

(2) THAT A DENTAL HEALTH EDUCATION AND ORAL HYGIENE INSTRUCTION PROGRAM BE DEVELOPED AND OFFERED TO SPECIAL GROUPS SUCH AS, THE HANDICAPPED, PARENTING GROUPS, PRE-SCHOOL REGISTRANTS AND CHILDREN IN DAY CARE AND NURSERY GROUPS AND TO THE COMMUNITY AT LARGE.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) number of schools receiving the program,

(ii) number of classrooms,

(iii) the grades involved,

(iv) number of children,

(v) number of special groups receiving the program,

(vi) number of participants in each special group,

(vii) number of community presentations and activities.

(c) The above records shall be maintained for use in completing the annual Ministry of Health Survey of Health Unit Information.

(2) Staffing

The dental health education and oral hygiene instruction program shall be carried out under the direction of a qualified public health dentist. The education and instruction activities shall be conducted by appropriately trained dental health educators.

(3) Program Delivery

(a) It is recommended that the dental health education and oral hygiene instruction programs be developed so as to complement each other and that instructors use suitable training aids, such as:

(i) appropriate dental health materials,

(ii) audio visual aids,

(iii) models,

(iv) posters and pamphlets,

(v) activity sheets...

(b) Under item 1 (b)(i) of the Standard a written nutrition education component shall be developed jointly by staff of the Dental and Nutrition Divisions, reviewed annually and updated as requested.

(i) The staff nutritionist(s) shall meet with the dental staff at least once per year to discuss and/or provide in-service education on the

nutrition component of the dental health education program.

(ii) The staff nutritionist shall provide orientation of the nutrition component to each new dental health educator.

(iii) The minimum nutrition content shall include the multifactorial nature of dental disease and the importance of nutrition in its prevention.

(iv) The nutrition content may be presented briefly in each dental health lesson for all grade levels; or be presented in depth in at least three dental health lessons (once in K-3, once in 4-6, and once in 7-8).

(c) Where a preschool registration program exists the parent and child shall receive dental counselling, including dental/nutritional information.

(d) The improvement of the oral health of the community in an effective and efficient manner can be enhanced by the use of appropriate community resources particularly the co-operation from the private dental practitioners and elementary school teaching staff.

PART III

SCREENING AND REFERRAL PROGRAM INCLUDING DENTAL HEALTH SURVEY

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT EACH YEAR, WITH THE CONCURRENCE OF THE LOCAL SCHOOL BOARD, A DENTAL SCREENING EXAMINATION BE OFFERED TO CHILDREN AGED 5,7,9,11,13 AND 15.

(2) THAT EACH CHILD EXAMINED AND FOUND TO BE IN NEED OF DENTAL CARE BE PROVIDED WITH A REFERRAL CARD.

(3) THAT WHERE THE SCREENING EXAMINATION INDICATES EITHER AN IMMEDIATE/ACUTE DENTAL CONDITION, OR AN URGENT DENTAL CONDITION, THE PUBLIC HEALTH DENTIST SHALL TAKE APPROPRIATE ACTION CONSISTENT WITH ESTABLISHED PROFESSIONAL STANDARDS OF PRACTISE.

(4) THAT EVIDENCE OF THE ORAL CONDITIONS OF CHILDREN SCREENED SHALL BE SUBMITTED TO THE MINISTRY ON AN ANNUAL BASIS IN A PRESCRIBED FORM.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) number of schools in the program,

(ii) number of children screened,

(iii) number of referrals,

(iv) number of follow-ups,

(v) number of children followed up who are receiving care.

(2) Staffing

(i) This program shall be carried out under the direction of a qualified public health dentist.

(ii) Only licensed dentists or dental hygienists will conduct intra-oral screening.

(iii) Appropriately trained staff will act as recorders.

(3) Program Delivery

(a) Under item (3) of the Standard the following definitions shall be used.

(i) Immediate/acute conditions are:

- Pain
- Infection
- Haemorrhage
- Trauma

(ii) Urgent conditions are those shortly leading to pain, infection and haemorrhage such as:

1. Open carious lesion with obvious loss of tooth structure in any permanent or crucial primary tooth.

2. Periodontal disease which is not reversible by adequate oral hygiene.

(b) The intent of item (4) of the Standard can be met by adherence to the Current Ministry of Health, "Ontario Dental Health Indices Health Unit Procedures" Manual.

PART IV

TOPICAL FLUORIDE PROGRAM

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT SPECIAL TARGET GROUPS* IN BOTH FLUORIDE AND NON-FLUORIDE AREAS BE OFFERED INDIVIDUAL TOPICAL FLUORIDE APPLICATIONS AND/OR DENTAL HEALTH INSTRUCTION.

(2) THAT, IF DURING THE TOPICAL FLUORIDE APPLICATION, IMMEDIATE/ACUTE OR URGENT DENTAL CONDITIONS ARE NOTED, THE PUBLIC HEALTH DENTIST SHALL TAKE APPROPRIATE ACTION CONSISTENT WITH ESTABLISHED PROFESSIONAL STANDARDS OF PRACTISE.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) number of children receiving the program,

(ii) number of children referred,

(iii) number of children referred who are subsequently given dental treatment.

(2) Staffing

(i) The topical fluoride program shall be carried out under the direction of a qualified public health dentist.

(ii) Only licensed dentists or dental hygienists will conduct the intra-oral procedures.

(iii) Adequately trained staff may act as dental assistants.

* Special Target Groups include:

(a) Preschool children.
(b) Handicapped children.
(c) Children exhibiting high caries activities.
(d) Migrant children from low fluoride areas.

(3) Program Delivery

(a) Parental consent is required for children participating in the program.

(b) Under item (1) of the Standard, individual counselling in good dental health habits including proper nutrition shall be provided.

(c) Also under item (1) of the Standard, each eligible child will receive a dental prophylaxis if required and an application of fluoride gel.

(d) Under item (2) of the Standard the following definitions shall be used:

(i) Immediate/acute conditions are:

Pain

Infection

Haemorrhage

Trauma

(ii) Urgent conditions are those shortly leading to pain, infection or haemorrhage such as:

1. Open carious lesion with obvious loss of tooth structure in any permanent or crucial primary tooth.

2. Periodontal disease which is not reversible by adequate oral hygiene.

(e) Any child identified in need of dental care under item (2) of the Standard shall receive a referral card.

PART V

GERIATRIC PROGRAM

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT EACH PERSON ATTENDING REGULARLY AT A COLLECTIVE LIVING CENTRE* BE OFFERED A SCREENING EXAMINATION ONCE EVERY TWO YEARS IN ORDER TO IDENTIFY PERSONS REQUIRING DENTAL CARE FOR REFERRAL AND TO MEASURE DENTAL HEALTH STATUS.

(2) THAT THE SCREENING EXAMINATION BE SUPPLEMENTED WITH THE FOLLOWING PREVENTIVE MEASURES AS NECESSARY:

(a) MECHANICAL PLAQUE CONTROL.

(b) CLEANING AND IDENTIFICATION OF PROSTHETIC APPLIANCES.

(c) APPLICATION OF TOPICAL FLUORIDES.

(3) THAT STAFF AND RESIDENTS OF COLLECTIVE LIVING CENTRES* BE OFFERED AT LEAST ONE DENTAL HEALTH EDUCATIONAL SEMINAR PER YEAR. THE SEMINAR SHALL BE AT LEAST ONE HOUR IN DURATION AND CONTAIN A NUTRITION COMPONENT.

(4) THAT THE DENTAL DIRECTOR OFFER ADVISORY SERVICES TO COLLECTIVE LIVING CENTRES* AND GERIATRIC GROUPS.

IMPLEMENTATION

1. Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) the number of persons screened,

(ii) the number of persons referred,

* Collective Living Centres include:

Senior Citizens Apartments.
Drop In Centres.
Homes for the Aged.
Nursing Homes.
Chronic Care Hospitals.
Chronic Wards in acute treatment hospitals.

(iii) the number of those referred who are receiving care within a two month period,

(iv) the number and type of preventive measures provided by the dental public health staff as a follow-up to screening.

(v) the number of education programs offered, the number of participants and the type of collective living centre in which the program is offered.

(2) Staffing

The Geriatric Dental Program shall be carried out under the direction of a qualified public health dentist.

The intra oral procedures identified in items (1) and (2) of the Standard shall be conducted by a licensed dentist or dental hygienist and conform to the regulations under the Health Disciplines Act.

The dental health education component of item (3) of the Standard may be conducted by either a dental hygienist or a dental health educator in consultation with the public health nutritionist.

(3) Program Delivery

(a) In carrying out the preventive measures specified in the Standard, dental public health staff will develop a referral mechanism, through the staff of the facility, which will ensure follow-up within a two month period.

(b) The content of the dental public health education program is to be determined by the Public Health Dentist employed by the Board.

(c) In addition to the programs identified in item (3) of the Standard, a dental health education component shall be included in Health Unit in-service education as the need arises.

(d) Where a Community College Nursing and/or Dental Auxiliary Program exists in the Health Unit, the public health dental staff shall offer a liaison mechanism with a view to provide input periodically.

(e) Staff of the Board will inform the Community through the Media, etc., that the dental program offered in the Standard will be available to all senior citizens (65 years of age and older) through a drop in centre or Health Unit Office.

December 1982

DRAFT FOR COMMENT

NOT MINISTRY POLICY

DRAFT GUIDELINES

FOR

NUTRITION PROGRAM*

- Identification of Community Nutrition Needs
- Nutrition Services to Board of Health Programs
- Nutrition Services to the Community

Committee Members

- Helen Brown, Senior Nutrition Consultant, Public Health Branch, Ministry of Health (Committee Chairman)
- Denise Beatty, Nutritionist, Etobicoke Health Department (Ontario Society of Nutritionists in Public Health)
- Barbara Engle, Nutrition Consultant, Public Health Branch, Ministry of Health
- Rita Foscarini, Nutritionist, Renfrew Health Unit (Ontario Society of Nutritionists in Public Health)
- Dr. Cecile Rochard, Medical Officer of Health, Oxford County Health Unit (Society of Medical Officers of Health)

* Names of core program services have been changed. See explanatory footnotes on the following pages. Also Phase I Guidelines distributed in 1981 have been revised by Ministry staff to conform to the new format and they appear within the attached document.

GUIDELINES FOR THE PROVISION OF MANDATORY PROGRAMS

UNDER THE PROVISION OF

THE HEALTH PROTECTION ACT -- SECTION 7

NUTRITION

PART 1

IDENTIFICATION OF COMMUNITY NUTRITION NEEDS*

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT AN ASSESSMENT OF THE NUTRITION NEEDS OF THE POPULATION RESIDING IN THE HEALTH UNIT BE UNDERTAKEN AND THAT THIS ASSESSMENT BE MONITORED AND UPDATED BIENNIALLY.

(2) THAT STRATEGIES BE DEVELOPED TO MEET THESE IDENTIFIED NEEDS.

IMPLEMENTATION

(1) Program Administration

The Medical Officer of Health shall be responsible for ensuring the preparation of an Operational Plan pertaining to the Standard.

Records shall be maintained indicating the following:

(a) the number and type of agencies contacted and information sources used in the needs assessment.

(b) the results of the needs assessment process. This shall include a listing of the needs which have been identified and the order in which they will be addressed in the strategy required by Item (2) of the Standard.

(c) the number and type of agencies contacted for strategy development.

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* Formerly called: "Identification of Unmet Community Nutrition Needs" (Phase One)

(2) Staffing

The identification of community nutrition needs shall be carried out under the direction of a person qualified in public health nutrition. Other health professionals may assist in the implementation of this service.

Ongoing and regular professional development, with appropriate funding and resources, shall be available to the nutrition staff.

(3) Program Delivery

The identification of community nutrition needs shall include but not be limited to the following two steps:

(a) Community Needs Assessment

(b) Strategy Development

Community needs assessment shall include:

(i) the identification of local health and related agencies and groups involved or having the potential to be involved in nutrition.

(ii) the collection and compilation of available data/information which can provide insight into existing or potential nutrition needs.

(iii) an analysis of the information collected which may include consultation with other appropriate individuals.

Strategy development shall include the development of strategies to address the identified needs in co-operation with the agencies, groups and individuals who are likely to be the providers of the services required.

PART II

NUTRITION SERVICES TO BOARD OF HEALTH PROGRAMS*

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT A NUTRITION EDUCATION COMPONENT BE DEVELOPED FOR AND INCLUDED IN AT LEAST EACH OF THE FOLLOWING BOARD OF HEALTH PROGRAMS:

(a) FAMILY PLANNING.

(b) MATERNAL/PARENTAL HEALTH.

(c) INFANT HEALTH.

(d) PRESCHOOL HEALTH, INCLUDING DENTAL HEALTH.

(e) SCHOOL HEALTH, INCLUDING DENTAL HEALTH.

(f) ADULT HEALTH.

(g) GERIATRIC HEALTH.

(2) THAT EACH NUTRITION EDUCATION COMPONENT IDENTIFY THE APPROPRIATE FOOD CHOICES NECESSARY TO MEET THE NUTRIENT AND ENERGY REQUIREMENTS FOR EACH STAGE IN THE LIFECYCLE IN ITEM (1). LIFESTYLE INFLUENCES SUCH AS ECONOMIC, SOCIAL, AND CULTURAL FACTORS MUST ALSO BE TAKEN INTO ACCOUNT.

(3) NOTWITHSTANDING ITEM (2) THE NUTRITION EDUCATION COMPONENT FOR EACH PROGRAM SHALL ALSO INCLUDE BUT NOT BE LIMITED TO:

(a) FAMILY PLANNING: PRE-CONCEPTUAL NUTRITION; THE EFFECT OF CONTRACEPTIVE METHODS ON NUTRITIONAL NEEDS.

(b) MATERNAL/PARENTAL HEALTH:

PRENATAL: NUTRITIONAL FACTORS INFLUENCING PREGNANCY OUTCOME; DESIRABLE WEIGHT GAIN; FACTORS INFLUENCING FOOD CHOICES; NUTRITIONAL BENEFITS OF BREASTFEEDING.

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* Formerly Called "Nutrition Education" (New Guideline)

Note:

The Maternal/Parental Health and Dental Health Education Components of this guideline are Phase One. The remaining components (Family Planning, Geriatric....) are "New Guidelines".

POSTNATAL: NUTRITIONAL NEEDS OF BREASTFEEDING MOTHER; NUTRITIONAL NEEDS OF INFANT (SEE INFANT HEALTH).

(c) INFANT HEALTH: NUTRITIONAL CONSIDERATIONS WITH BREAST AND FORMULA FEEDING; INTRODUCTION OF SOLID FOODS.

(d) PRESCHOOL HEALTH INCLUDING DENTAL HEALTH: COMMON EATING PROBLEMS; ESTABLISHING GOOD EATING HABITS; SNACKING AND DENTAL HEALTH.

(e) SCHOOL HEALTH INCLUDING DENTAL HEALTH: SNACKING AND DENTAL HEALTH; DESIRABLE BODY WEIGHT; COMMON EATING PROBLEMS.

(f) ADULT HEALTH: DESIRABLE BODY WEIGHT; DIETARY MODIFICATION FOR OPTIMAL HEALTH AND DISEASE PREVENTION.

(g) GERIATRIC HEALTH: DIETARY MODIFICATION FOR OPTIMAL HEALTH, DISEASE PREVENTION AND CONTROL.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual Operational Plan pertaining to the Standard.

(b) Records shall be maintained, for each calendar year, for the nutrition education component of each Board of Health program indicating the following:

(i) written outline of the nutrition education component stating objectives, program content and nutrition resources.

(ii) number and type of consultations provided by the nutritionist to Board of Health staff including inservice education regarding program delivery.

(iii) annual review of written nutrition education component and resources has occurred, with revision as required.

(2) Staffing

The nutrition education program shall be carried out under the direction of a person qualified in public health nutrition and may be delivered by Board of Health staff as appropriate.

Ongoing and regular professional development, with appropriate funding and resources, shall be available to the nutrition staff.

(3) Program Delivery

(a) It is recommended that the nutrition education component be developed and updated in collaboration with public health nurses and other Board of Health staff as necessary.

(b) Items (1), (2), and (3) of the Standard will be satisfied if the following minimum activities are undertaken:

(i) consultation, including inservice education and orientation, for appropriate Board of Health staff as required.

(ii) annual review and revision as needed, of the written nutrition education component.

(iii) development and provision of nutrition resource materials as needed.

PART III

NUTRITION SERVICES TO THE COMMUNITY*

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT A NUTRITION EDUCATION, INFORMATION AND ADVISORY SERVICE IS MADE AVAILABLE TO THE COMMUNITY. THIS SERVICE SHALL INCLUDE BUT NOT BE LIMITED TO:

(a) THE ESTABLISHMENT AND MAINTENANCE OF LIAISON WITH AGENCIES AND GROUPS PROVIDING NUTRITION OR RELATED SERVICES WITHIN THE HEALTH UNIT.

(b) THE PROVISION OF NUTRITION EDUCATION, INFORMATION AND CONSULTATION TO COMMUNITY AGENCIES AND GROUPS SUCH AS HEALTH, EDUCATION, RECREATION AND SOCIAL SERVICES, AND THE MASS MEDIA.

(c) THE DEVELOPMENT AND OR PROVISION OF NUTRITION RESOURCE MATERIALS.

(d) THE PREPARATION AND DISTRIBUTION OF A DIRECTORY OR LISTING OF NUTRITION SERVICES AND RESOURCES AVAILABLE TO THE COMMUNITY. THE DIRECTORY OR LISTING SHALL BE UPDATED ANNUALLY.

(e) REFERRAL TO OTHER SERVICES/RESOURCES.

(2) THAT THE AVAILABILITY OF THE SERVICE SET OUT IN ITEM (1) BE PROMOTED TO THE COMMUNITY.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual Operational Plan pertaining to the Standard.

(b) Records shall be maintained for each calendar year indicating the following:

(i) the groups reached.

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* Combines the two services originally called: "Liaison With Community Agencies/Orgainzations/Groups" (Phase One) and "Nutrition Consultation" (New Guideline)

(ii) the number and subject area of nutrition education, information and advisory services provided.

(iii) a listing of persons to whom the Directory or Listing has been sent.

(iv) a listing of activities carried out to promote the nutrition services to the community.

(2) Staffing

The nutrition education, information and advisory service shall be carried out under the direction of a person qualified in public health nutrition. Other persons may assist in the delivery of this service.

Ongoing and regular professional development, with appropriate funding and resources, shall be available to the nutrition staff.

(3) Program Delivery

Item (1) and (2) of the Standard will be satisfied if the following minimum activities are undertaken:

(i) development and provision of nutrition resource materials such as pamphlets, newsletters or teaching manuals.

(ii) development of a nutrition component for appropriate community programs.

(iii) consultation, including workshops and presentations.

(iv) mass media work that could include doing a radio or television program, being interviewed or writing an article for a newspaper.

December 1982

DRAFT ONLY

NOT MINISTRY POLICY

DRAFT GUIDELINES

FOR

FAMILY HEALTH PROGRAM

- Maternal/Parental Health*
- Family Planning
- Preschool Health
- School Health
- Adult Health
- Geriatric Health
- Mental Health

(* Phase I Guidelines distributed in 1981 have been revised by Ministry staff to conform with new guidelines format.)

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Maternal Parental Health

(Guidelines revised by Dr. Roch Khazen to conform to new format)

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GUIDELINES FOR THE PROVISION OF MANDATORY PROGRAMS

UNDER THE PROVISION OF

THE HEALTH PROTECTION ACT -- SECTION 7

FAMILY HEALTH

PART I - MATERNAL & PARENTAL HEALTH SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT THE STAFF ESTABLISH REGULAR CONTACT WITH PHYSICIANS AND HEALTH AND SOCIAL AGENCIES IN THE HEALTH UNIT AREA IN ORDER TO ENSURE THAT PREGNANT WOMEN ARE ABLE TO OBTAIN EARLY PRENATAL CARE SUCH AS THROUGH THEIR FAMILY PHYSICIAN OR COMMUNITY OR HOSPITAL CLINIC.

(2) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO IDENTIFY PREGNANT WOMEN AT HIGH RISK.

(3) THAT A COUNSELLING SERVICE BE MADE AVAILABLE TO PREGNANT WOMEN IDENTIFIED AS HIGH RISK.

(4) THAT A REFERRAL AND FOLLOW UP MECHANISM BE DEVELOPED IN ORDER TO ENSURE THAT SUCH COUNSELLING SERVICE IS AVAILABLE TO HIGH RISK WOMEN AT ANYTIME THROUGHOUT THE PREGNANCY PERIOD.

(5) THAT CHILDBIRTH EDUCATION CLASSES BE MADE AVAILABLE TO EXPECTANT PARENTS AND THAT:

   (a) PRIORITY FOR ATTENDANCE BE GIVEN TO FIRST PREGNANCIES AND HIGH RISK PARENTS.

   (b) CLASSES BE NOT LESS THAN SEVEN IN NUMBER WITH A MINIMUM DURATION OF 1½ HOURS PER CLASS FOR INSTRUCTION AND EXERCISE.

   (c) PREGNANT WOMEN BE ENCOURAGED TO COMMENCE CLASSES NOT LATER THAN THE 3RD MONTH OF PREGNANCY AND TO CONTINUE ATTENDANCE UNTIL THE FOURTH WEEK POST DELIVERY OR DISCHARGE FROM HOSPITAL.

(6) THAT REFRESHER CHILDBIRTH EDUCATION CLASSES ARE AVAILABLE FOR MULTIPARA WITH THE NUMBER OF HOURS OF INSTRUCTION BEING VARIABLE ACCORDING TO DEMAND AND NEED.

(7) THAT THE CONTENT OF CHILDBIRTH EDUCATION CLASSES CONTAIN BUT NOT BE LIMITED TO:

(a) PRENATALLY: REPRODUCTION AND CHANGES DURING PREGNANCY; NUTRITION; WEIGHT GAIN, PREPARATION FOR BREASTFEEDING; DELIVERY PROCESS; HOSPITAL CARE; SPECIAL CARE; FITNESS AND EXERCISES; RELAXATION; FAMILY ADJUSTMENTS; ROLE OF PARTNER; EFFECT OF SUBSTANCE USE AND ABUSE; DENTAL CARE; ETC.,

(B) POSTNATALLY: INFANT CARE AND NUTRITION; BREASTFEEDING; FAMILY ADJUSTMENTS; IMMUNIZATION; SAFETY; PARENTING; PRINCIPLES OF GROWTH AND DEVELOPMENT; POST-PARTUM CARE; FAMILY PLANNING.

(8) THAT A HOMEVISITING SERVICE BE MADE AVAILABLE ON REQUEST TO:

(a) THOSE PREGNANT WOMEN GIVING BIRTH FOR THE FIRST TIME WHO HAVE NOT ATTENDED CHILDBIRTH EDUCATION CLASSES. SUCH SERVICE TO CONSIST OF A MINIMUM OF ONE POST NATAL VISIT, NOT LATER THAN 4 WEEKS AFTER BIRTH OR AFTER DISCHARGE FROM HOSPITAL.

(b) OTHER HIGH RISK POST-PARTUM WOMEN.

(c) OTHER POST-PARTUM WOMEN ON REQUEST.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) the number of home visits made to pregnant and post-partum women,

(ii) the number of childbirth education classes conducted,

(iii) the number of pregnant women and partners attending the childbirth education classes, by age and parity.

(2) Staffing

The services and activities referred to in the Standard shall be carried out by public health nurses under the direction of the senior ranking public health nurse, with other health care professionals being employed where appropriate.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met through establishing liaison with physicians and agencies/institutions which provide services to women of child bearing age e.g. high schools, community clinics, social and welfare agencies, voluntary groups, physician group practice etc.,

(b) The intent of item (2) of the Standard may be met through the development of a list of criteria or indicators which can be used to identify service priorities. Such indicators might include:

(i) Critical child bearing ages.

(ii) At risk socio-economic groups.

(iii) Critical parity status ...

(c) In complying with the intent of items (5), (6) and (7) of the Standard, staff shall ensure that childbirth education classes have flexibility of content based on client needs. Separate classes for special groups, i.e. teenage parents, C-section groups ... should be considered if the number of parents attending classes warrants it.

In addition, educational activities through mass media to promote good prenatal care and lifestyle is advocated.

(d) The Board of Health may provide childbirth education classes through an agreement with another agency e.g. hospital, community college, etc. In such instances, the agreement shall include provisions pertaining to at least the following matters:

(i) number of hours for instruction,

(ii) qualification of instructors,

(iii) liaison mechanism with health unit,

(iv) content of classes,

(v) data collection relating to number of pregnant women and partners attending by age and parity...

PART II

FAMILY PLANNING SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT INFORMATION ON FAMILY PLANNING SERVICES BE AVAILABLE AND PROMOTED TO THE COMMUNITY, WITH EMPHASIS ON GROUPS WITH SPECIAL NEEDS SUCH AS ADOLESCENTS.

(2) (a) THAT EDUCATIONAL PROGRAMS ON FAMILY PLANNING BE MADE AVAILABLE TO BOTH SEXES WITH PRIORITY BEING GIVEN TO GROUPS AT HIGH RISK WITH SPECIAL NEEDS SUCH AS ADOLESCENTS.

(b) THE CONTENT OF EDUCATIONAL PROGRAMS SHALL INCLUDE BUT NOT BE LIMITED TO:

(i) FERTILITY AWARENESS.

(ii) HUMAN SEXUALITY AS IT RELATES TO FERTILITY.

(iii) BIRTH CONTROL.

(iv) INFORMATION AIMED AT FOSTERING THE USE OF FAMILY PLANNING METHODS.

(c) EDUCATIONAL PROGRAMS IN FAMILY PLANNING SHALL BE INTEGRATED AND CO-ORDINATED WITH OTHER RELATED HEALTH UNIT EDUCATION PROGRAMS SUCH AS THOSE ASSOCIATED WITH THE CONTROL OF LIFESTYLE DISEASES AND SEXUALLY TRANSMITTED DISEASES, PARENTING, INFANT HEALTH...

(3) THAT A FAMILY PLANNING REFERRAL SYSTEM BE DEVELOPED AND IMPLEMENTED; SUCH A SYSTEM TO INCLUDE A MECHANISM FOR ASSISTING CLIENTS IN OBTAINING THE SERVICES OF PHYSICIANS, HOSPITAL CLINICS, HEALTH UNIT CLINICS AND OTHER COMMUNITY AGENCIES.

(4) THAT COUNSELLING SERVICES BE AVAILABLE TO MEET THE NEEDS OF PERSONS RESIDING IN THE HEALTH UNIT; SUCH SERVICES TO INCLUDE, BUT NOT BE LIMITED TO:

(a) HEALTH AND LIFESTYLE ASSESSMENT.

(b) COMPREHENSIVE PREGNANCY COUNSELLING.

(c) REFERRAL AS PER ITEM 3 AS NECESSARY.

(5) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO IDENTIFY HIGH RISK GROUPS AND GROUPS WITH SPECIAL NEED, SUCH AS ADOLESCENTS.

(6) (a) THAT FAMILY PLANNING CLINICAL SERVICES BE AVAILABLE, ACCESSIBLE AND APPROPRIATE TO MEET LOCAL NEEDS, AND GROUPS WITH SPECIAL NEED. SUCH SERVICES MAY INCLUDE THE ESTABLISHMENT OF HEALTH UNIT CLINICS.

(b) WHERE CLINICS ARE ESTABLISHED, ACTIVITIES UNDERTAKEN MAY INCLUDE:

(i) CLIENT'S HEALTH AND LIFESTYLE ASSESSMENT.

(ii) PELVIC, BREAST EXAMINATION AND PAP SMEAR ON EACH NEW FEMALE CLIENT.

(iii) LABORATORY TESTS AT THE DISCRETION OF THE PHYSICIAN, SUCH AS TEST FOR S.T.D., RUBELLA IMMUNITY...

(iv) THE DEVELOPMENT OF AN APPROPRIATE MANAGEMENT PLAN.

(v) FOLLOW-UP AND REFERRAL WHERE INDICATED.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be consistent with the information required by the Ministry of Health through its "Family Planning Monthly Summary" Report. Records shall be maintained indicating the following:

(i) Age of clients, marital status.

(ii) Service requested.

(iii) Number and type of laboratory test undertaken.

(iv) Number of field visits.

(v) Number of counselling activities held and the location thereof.

(2) Staffing

(a) The services and activities referred to in the Standard shall be carried out by public health nurses under the direction of the senior ranking public health nurse, with other health care professionals being employed where appropriate.

(b) Full time staff employed under the Family Planning Program Budget shall normally limit their activities to those associated with family planning services.

(3) Program Delivery

(a) The intent of items (1), (2) and (4) of the Standard may be meet by:

(i) the provision of consultation to groups or community agencies such as hospitals, youth associations, pharmacies, children's services, home and school associations, colleges and schools,

(ii) the distribution of suitable reference and educational materials,

(iii) the sponsorship,co-sponsorship, and participation of staff in seminars, workshops, or in-service education to various community and professional groups,

(iv) the development of a broad based advisory community group chaired by the Medical Officer of Health or his/her delegate.

(b) The intent of item (5) of the Standard may be met through the development of a list of criteria or indicators (a "risk indicator list") which can be used to identify service priorities. Such indicators may include statistics on: pregnancy loss by age groups, age specific fertility rates, marriage rates, incidence of S.T.D., etc.,

(c) Under item (6) of the Standard, the Board may provide clinic service, through an agreement, by another agency. In such instances the Board through its staff will, in addition to the provision of funds, act in a monitoring and liaison capacity in order to ensure:

(i) that Ministry of Health and Board of Health policies and procedures are adhered to,

(ii) that staff selection and roles conform to acceptable practice of the Board of Health,

(iv) that reporting and data collection mechanisms are established consistent with Ministry of Health requirements.

(c) In order to maintain and enhance staff competance in family planning, staff should be given the opportunity to update their knowledge through attendance at suitable training programs. In addition they should have access to current reference and educational materials.

PART III

INFANT HEALTH SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT A MECHANISM FOR REGULAR CONTACT WITH PHYSICIANS, HEALTH AND SOCIAL AGENCIES BE ESTABLISHED SO AS TO ENSURE THAT APPROPRIATE CARE IS AVAILABLE TO HIGH RISK INFANTS SUCH AS THROUGH THE FAMILY PHYSICIAN, HOSPITAL OR COMMUNITY CLINICS.

(2) THAT A HOME VISITING SERVICE BE AVAILABLE ON REQUEST (AS PER ITEM (1):

(a) TO FAMILIES WITH HIGH RISK INFANTS. SUCH SERVICE TO CONSIST OF A MINIMUM OF ONE POST-NATAL VISIT NOT LATER THAN 4 WEEKS AFTER BIRTH OR INFANT'S DISCHARGE FROM HOSPITAL.

(b) TO OTHER FAMILIES WITH AN INFANT, ON REQUEST.

(3) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO IDENTIFY HIGH RISK INFANTS.

(4) IN ADDITION TO ITEM (3) ABOVE, THAT PROCEDURES BE DEVELOPED SO AS TO ENSURE REFERRAL AND FOLLOW-UP OF HIGH RISK INFANTS AND THE PROVISION OF SUPPORT AS NEEDED TO FAMILIES OF SUCH INFANTS.

(5) THAT VISITING AND COUNSELLING SERVICES BE AVAILABLE TO DAY NURSERIES, DAY CARE CENTRES AND FOSTER HOMES WHICH PROVIDE SERVICES AND CARE TO INFANTS.

(6) THAT PARENTING CLASSES BE MADE AVAILABLE FOR HIGH RISK PARENTS AND ON REQUESTS; SUCH CLASSES TO CONTAIN BUT NOT BE LIMITED TO:

(a) INFANT CARE AND NUTRITION.

(b) BREASTFEEDING.

(c) FAMILY ADJUSTMENT.

(d) IMMUNIZATION.

(e) INFANT STIMULATION.

(f) PARENTING.

(g) PRINCIPLES OF GROWTH AND DEVELOPMENT.

(h) FAMILY PLANNING.

(i) SAFETY.

(7) THAT COMMUNITY PUBLIC EDUCATION PROGRAMS IN INFANT HEALTH AND ACCIDENT PREVENTION BE AVAILABLE ON REQUEST.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) number of home visits made,

(ii) number of parenting classes conducted,

(iii) number of persons attending the parenting classes,

(iv) number of visits to day care centres, nurseries and foster homes.

(2) Staffing

The services and activities referred to in the Standard shall be carried out by public health nurses under the direction of the senior ranking public health nurse, with other health care professionals being employed where appropriate.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met through establishing liaison with physicians and agencies/hospitals/institutions which provide services to women of childbearing years and infants. In particular strong liaison should be developed with Ministry of Community & Social Services workers and Crippled Children Agencies in the health unit.

(b) Under item (2) of the Standard a home visit shall be done by a public health nurse and shall include but not be limited to providing the following services:

(i) A health assessment including hearing testing where appropriate.

(ii) A developmental assessment where appropriate.

(iii) Counselling on growth and development.

(iv) Information/advice on family adjustment.

(v) Information/advice on breastfeeding and infant nutrition.

(vi) Information/advice on immunization.

(vii) Information/advice on infant safety.

(viii) Information/advice on family planning.

(c) The intent of item (3) of the Standard may be met through the development of a list of criteria or indicators (a "risk indicator" list) which can be used to identify service priorities. Such indicators may include:

(i) Low birth weight.

(ii) Congenital abnormality.

(iii) Socio-Economic status of parents.

(iv) Teenage parents.

(v) Potential child abuse family.

(d) Under item (6) the Board may ensure the provision of parenting classes through an agreement with other agencies. In such instances, the agreement shall include provisions pertaining to at least the following:

(i) number of hours for instruction,

(ii) qualification of instructors,

(iii) liaison mechanism with health unit,

(iv) content of classes,

(v) data collection relating number of parent(s) attending by age, parity and age of infants...

(e) In addition, use of the media to promote good parenting, safety, infant nutrition, breastfeeding ... is recommended as an adjunct and addition to parenting classes.

PART IV

PRESCHOOL* HEALTH SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT A MECHANISM FOR REGULAR CONTACT WITH PHYSICIANS, HEALTH AND SOCIAL AGENCIES BE ESTABLISHED SO AS TO ENSURE THAT APPROPRIATE CARE IS AVAILABLE TO HIGH RISK PRESCHOOL CHILDREN AND THEIR FAMILIES.

(2) THAT A HOME VISITING SERVICE BE MADE AVAILABLE ON REQUEST SO AS TO ENSURE THAT APPROPRIATE CARE IS AVAILABLE TO:

   (a) FAMILIES WITH HIGH RISK PRESCHOOL CHILDREN; SUCH SERVICE TO INCLUDE AN IDENTIFICATION OF ACTUAL AND POTENTIAL HEALTH PROBLEMS.

   (b) OTHER FAMILIES WITH PRESCHOOL CHILDREN ON REQUEST.

(3) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO IDENTIFY HIGH RISK PRESCHOOL CHILDREN.

(4) IN ADDITION TO ITEM (3) ABOVE, THAT PROCEDURES BE DEVELOPED SO AS TO ENSURE THE REFERRAL AND FOLLOW-UP OF HIGH RISK PRESCHOOL CHILDREN AND THE PROVISION OF INFORMATION AND SUPPORT TO FAMILIES OF SUCH CHILDREN.

(5) THAT SERVICES SUCH AS HEARING, VISION AND DEVELOPMENT TESTING, COUNSELLING, NUTRITION ASSESSMENT BE AVAILABLE TO PRESCHOOL CHILDREN AND THEIR FAMILIES BASED ON NEED.

(6) THAT PARENTING CLASSES BE AVAILABLE TO PARENTS OF HIGH RISK PRESCHOOL CHILDREN AND ON REQUEST; SUCH CLASSES TO CONTAIN BUT NOT BE LIMITED TO:

   (a) GROWTH AND DEVELOPMENT.

   (b) CHILD STIMULATION.

   (c) NUTRITION.

   (d) SAFETY AND ACCIDENT PREVENTION.

   (e) DENTAL CARE.

   (f) IMMUNIZATION.

(* Defined as the period between one year of age to four years or to school entry.)

(7) THAT THE SERVICES OF BOARD OF HEALTH STAFF BE AVAILABLE AS REQUIRED TO STAFF OF NURSERIES, DAY CARE CENTRES, PRE-KINDERGARTEN AND SOCIAL AGENCIES.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) number of preschool children assessed by age,

(ii) number of children found to have impairments and type of impairment,

(iii) number of home visits made,

(iv) number of children needing follow-up,

(v) number of children identified as high risk,

(vi) number of parenting classes conducted,

(vii) number of persons attending the parenting classes,

(viii) population of nurseries, day care centres and prekindergarten,

(ix) number of visits to nurseries, day care centres, prekindergarten and social agencies.

(2) Staffing

The services and activities referred to in the Standard shall be carried out by public health nurses under the direction of the senior ranking public health nurse, and other health care professionals being employed where appropriate.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met through establishing liaison with physicians, health and social agencies, hospitals and institutions which provide services to preschool children and their families.

(b) Under item (2) of the Standard a home visit shall be done by a public health nurse. The components of the

home visit nursing assessment to be carried out shall be decided on a rational basis relating to the age and needs of the child. These components may include but not be limited to:

(i) health history or assessment,

(ii) immunization history,

(iii) hearing testing,

(iv) vision testing,

(v) developmental testing,

(vi) counselling,

(vii) nutrition assessment.

(c) The intent of item (3) of the Standard may be met through the development of a list of criteria or indicators (a "risk indicator" list) which can be used to identify service priorities.

(d) Under item (4) of the Standard the children found to have any visual, auditory or other noted impairment shall be referred through the parent to the appropriate consultant, i.e., family physician, eye consultant, ear consultant...

(e) Under item (6) of the Standard the Board of Health may ensure the provision of parenting classes through an agreement with other agencies. In such instances, the agreement shall include provisions pertaining to at leas: the following:

(i) number of hours for instruction,

(ii) qualification of instructors,

(iii) liaison mechanism with health unit,

(iv) content of classes,

(v) data collection relating to number of parent(s) attending by age, parity and age of children...

(f) The intent of item (7) of the Standard can be met through: meetings, seminars to day care/nurseries and provision of reference and health education material.

PART V

SCHOOL HEALTH SERVICES

NOTE: THE PROVISION OF SCHOOL HEALTH SERVICES WILL BE CONTINGENT UPON COMPLIANCE WITH SECTION 6 OF THE HEALTH PROTECTION ACT

INTRODUCTION

THE BOARD OF HEALTH SHALL ESTABLISH A SCHOOL HEALTH PROGRAM WITH A NUMBER OF COMPONENTS WHICH MAY BE ADOPTED BY A SCHOOL BOARD. THE COMPONENTS WILL BE AS FOLLOWS:

STANDARD

THE BOARD OF HEALTH SHALL:

(1) PROVIDE CONSULTATION ON SCHOOL HEALTH PROGRAMS TO SCHOOL BOARDS AND THEIR STAFF.

(2) DEVELOP PROCEDURES FOR IDENTIFYING AND REFERRING CHILDREN WITH HEALTH RELATED PROBLEMS.

(3) ENSURE THAT HEALTH PERSONNEL ARE AVAILABLE IN THE SCHOOL ON REGULAR OR REQUEST BASIS TO PROVIDE COUNSELLING ON HEALTH RELATED MATTERS.

(4) OFFER EACH CHILD ENTERING SCHOOL FOR THE FIRST TIME, A NURSING ASSESSMENT. THE ASSESSMENT WILL BE DONE AT REGISTRATION TIME OR AS SOON AS POSSIBLE THEREAFTER AND WILL INCLUDE, BUT NOT BE LIMITED TO:

   (i) TAKING A HEALTH HISTORY.

   (ii) A VISION TEST.

   (iii) A HEARING TEST.

(5) OFFER A PROGRAM FOR THE EARLY IDENTIFICATION OF VISION DEFECTS; SUCH PROGRAM TO INCLUDE:

   (i) A VISION SCREENING TEST AT SCHOOL ENTRY, BUT NOT LATER THAN AGE SIX; APPROXIMATELY AT GRADE 5 (AGE 10) AND GRADE 8 (AGE 13) IN ADDITION TO SCREENING TEST DURING PRESCHOOL YEARS.

   (ii) REFERRAL TO EYE CONSULTANT SUCH AS FAMILY PHYSICIAN, OPHTHALMOLOGIST, OR OPTOMETRIST AND FOLLOW UP OF CHILDREN IDENTIFIED TO HAVE VISION DEFECTS.

(6) OFFER A PROGRAM FOR THE EARLY IDENTIFICATION OF HEARING DEFECTS; SUCH PROGRAM TO INCLUDE:

(i) A HEARING SCREENING TEST AT SCHOOL ENTRY, AND AT GRADE 1 (AGE 6) - IN ADDITION TO ANY SCREENING TEST DURING PRESCHOOL TESTS.

(ii) REFERRAL TO EAR CONSULTANT SUCH AS FAMILY PHYSICIAN, OTOLOGISTOR OR AUDIOLOGIST AND FOLLOW UP OF CHILDREN IDENTIFIED AS HAVING HEARING DEFECTS.

7. ENSURE THAT IMMUNIZATION SERVICES BE AVAILABLE PURSUANT TO THE IMMUNIZATION OF SCHOOL PUPILS ACT.

8. ENSURE THAT DENTAL HEALTH SERVICES BE AVAILABLE AS REQUIRED UNDER THE PREVENTIVE DENTISTRY GUIDELINES.

9. ENSURE THAT NUTRITION SERVICES BE AVAILABLE AS REQUIRED UNDER THE NUTRITION GUIDELINES.

10. ENSURE THAT SUPPORT IN HEALTH EDUCATION AND PROMOTION BE AVAILABLE TO EDUCATION STAFF (E.G., PRINCIPAL, TEACHER, MEMBER OF CURRICULUM COMMITTEE...)

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the standard.

(b) Records shall be maintained indicating the following:

(i) Base population in the school.

(ii) Number of children assessed/tested by age and the results thereof.

(iii) Number of children referred for further assessment by age.

(iv) Type of impairment/disease found.

(v) Number of children requiring follow-up.

(vi) Outcome of follow-up.

Exchange of health information relating to immunization will be pursuant to the Immunization of School Pupils Act. Exchange of all other health information will be with parental consent.

Records shall be maintained separately on school children having health related problems and their families, as necessary.

(2) Staffing

The services and activities referred to in the Standard shall be carried out by public health nurses under the direction of the senior ranking public health nurse, with other health care professionals being employed where appropriate.

(3) Program Delivery

(a) The intent of item (1) of the Standard can be met through regular meetings with health and education officials.

(b) The intent of item (2) of the Standard may be met through:

(i) The development of a "risk indicator" list to facilitate the identification of high risk children.

(ii) Discussions with school staff.

(iii) Referrals to appropriate sources through parents.

(c) Under items (3), (4), (5) and (6) of the Standard referral of children suspected of having health, hearing or vision problems shall be through the parents to the family physician, eye consultant, or ear consultant as appropriate.

(d) The intent of item (10) of the Standard may be met through:

(i) Providing health education input as a representative on the curriculum Committee.

(ii) Making presentations at teachers' professional development days.

(iii) Providing suitable reference material.

PART VI

ADULT HEALTH SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) THAT AN ADULT HEALTH PROGRAM BE ESTABLISHED; SUCH PROGRAM TO INCLUDE BUT NOT BE LIMITED TO:

(a) THE PROVISION OF INFORMATION AND ADVICE ON SUCH MATTERS AS SMOKING AND HEALTH, SUBSTANCE ABUSE, AND OTHER MATTERS CONCERNED WITH THE PREVENTION AND CONTROL OF LIFESTYLE DISEASES.

(b) PROMOTION OF THE INDIVIDUAL'S RESPONSIBILITY FOR HIS/HER OWN HEALTH.

(c) THE PROVISION OF NURSING ASSESSMENT, EDUCATION, COUNSELLING, ADVOCACY, REFERRAL AND FOLLOW UP SERVICES BASED ON NEED.

(2) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO IDENTIFY HIGH RISK PERSONS AND GROUPS.

(3) THAT ON-GOING LIAISON BE ESTABLISHED AND MAINTAINED WITH PROFESSIONAL, VOLUNTARY AND OFFICIAL AGENCIES AND OTHER GROUPS WHO ARE INVOLVED IN PROVIDING HEALTH CARE AND HEALTH EDUCATION SERVICES TO ADULTS.

(4) THAT THE MEDICAL OFFICER OF HEALTH BE THE CHIEF SPOKESMAN FOR THE COMMUNITY IN MATTERS PERTAINING TO THE PREVENTION AND CONTROL OF LIFESTYLE DISEASES.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsibile for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) the number of contacts with individuals and agencies,

(ii) the time spent with community and professional groups, agencies and institutions,

(iii) the number of education programs and groups conducted,

(iv) the number of participants in the education programs and groups,

(v) the type of education programs and groups.

(2) Staffing

The services and programs referred to in the Standard shall be carried out by public health nurses under the direction of the senior ranking public health nurse, nutritionists, dental hygienists or other qualified health care professionals as necessary.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met through:

(i) Individual counselling.

(ii) Educational programs covering such topics as physical fitness, post coronary care, smoking and its effects, safety etc.

(iii) The use of mass media, newsletters, health fairs etc.

(iv) Referral to family physicians, self help support groups, recreational groups etc.

(b) The intent of item (2) of the Standard may be met through the development of a list of criteria or indicators (a "risk indicator" list) which can be used to identify service priorities. Such indicators may include statistics on:

(i) morbidity and mortality relating to lifestyle diseases: e.g. cancer of lung, coronary heart disease, mental ill health, alcoholism, accidents...

(ii) incidence of smoking, obesity, hypertension, substance abuse...

(c) The intent of item (3) of the Standard may be met through discussions and interagency meetings with groups/organizations working in the adult health field, to facilitate the development of a co-ordinated approach addressing adult health problems.

(d) Under item (4) of the Standard, the Medical Officer of Health would be the authoritative source of public health information in the Community and be an advocate for prevention in its broadest terms.

PART VII

GERIATRIC HEALTH SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) (a) THAT THE MENTAL, PHYSICAL AND SOCIAL WELL BEING NEEDS OF THE ELDERLY BE INCLUDED IN AS MANY OF ITS EDUCATIONAL PROGRAMS AS CONSIDERED APPROPRIATE BY THE MEDICAL OFFICER OF HEALTH.

(b) IN ADDITION TO (a) ABOVE, AN ADVISORY SERVICE BE AVAILABLE TO FAMILIES AND INDIVIDUALS WHO MAY REQUIRE ADVICE ON AGING AND THE NEEDS OF THE ELDERLY.

(2) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO DETERMINE THE HEALTH NEEDS OF THE ELDERLY AND TO IDENTIFY HIGH RISK GROUPS AND INDIVIDUALS.

(3) THAT IN ADDITION TO ITEM (2) POLICIES AND PROCEDURES BE DEVELOPED WHICH IDENTIFY:

(a) THE METHODS USED TO PLAN SERVICES.

(b) THE CRITERIA FOR THE SELECTION OF ELDERLY PERSONS AS ELIGIBLE FOR SERVICE.

(c) THE PROGRAMS AND SERVICES TO BE OFFERED IN THE HEALTH UNIT.

(4) THAT ONGOING CONTACT WITH OTHER AGENCIES, INSTITUTIONS AND ORGANIZATIONS BE ESTABLISHED AND MAINTAINED TO ENHANCE:

(a) THE CO-ORDINATION OF SERVICES AT BOTH THE COMMUNITY AND INDIVIDUAL LEVEL.

(b) THE REFERRAL OF INDIVIDUALS TO AND FROM OTHER ALLIED AGENCIES.

(c) INTERAGENCY PLANNING OF SERVICE DELIVERY, AND

(d) THE EXCHANGE OF INFORMATION ON IDENTIFIED NEEDS.

(5) THAT PROGRAMS FOR ELDERLY PERSONS BE AVAILABLE, SUCH PROGRAMS TO INCLUDE BUT NOT BE LIMITED TO:

(a) ASSESSMENT OF ELDERLY PERSONS IN ALL AREAS OF HEALTH INCLUDING MENTAL AND PHYSICAL HEALTH, SOCIAL WELL BEING, NUTRITION, LIFESTYLE, AND FUNCTIONAL ABILITY.

(b) MONITORING SERVICES, SUCH AS REGULAR HEALTH UNIT VISITS OR OTHER FOLLOW UP PROCEDURES ARRANGED IN THE

COMMUNITY, FOR ALL HIGH RISK ELDERLY PERSONS WHO HAVE BEEN IDENTIFIED BY THE HEALTH UNIT.

(c) COUNSELLING SERVICES FOR INDIVIDUALS/GROUPS WHICH PROMOTE THEIR OPTIMAL HEALTH AND ENHANCE THEIR ABILITY TO STAY IN THEIR OWN HOMES FOR AS LONG AS IS REASONABLE.

IMPLMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsible for the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be obtained indicating the following:

(i) source of referral

(ii) number of referrals

(iii) reason for referrals

(iv) disposition of referral

(v) response time

(vi) actual number of referrals accepted

(vii) number of referrals for which response could not be made

(viii) number of man hours for services both direct and indirect and to groups

(ix) number of individuals in groups

(x) number of contacts in groups

(xi) number of persons visited and frequency of visits

(xii) number of home visits

(xiii) reason for visits

(xiv) a list of high risk elderly monitored by health unit.

(2) Staffing

The services and activities referred to in the Standard may be carried out by public health nurses under the direction

of the senior ranking public health nurse. However because of the multi-disciplinary nature of the program, it is likely that other health unit professional staff will participate to some degree in the provision of services.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met through:

(i) the provision of health education information using the mass media, pamphlets, classes, mall displays and newsletters.

(ii) home visits, the provision of a written care plan, monitoring of the elderly based on individual needs, counselling and health supervision.

(b) The intent of item (2) of the Standard may be met through the development of a list of criteria or indicators (a "risk indicator" list) which can be used to identify service priorities. For example such indicators may include statistics on: demographics, epidemiologic data, number of elderly persons living alone, income level of the elderly, kinship support, etc.

(c) The intent of item (4) of the Standard may be met through the development of interagency co-ordinating mechanisms and may include regular group meetings, individual liaison etc.

PART VIII

COMMUNITY MENTAL HEALTH SERVICES

STANDARD

THE BOARD OF HEALTH SHALL ENSURE:

(1) (a) THAT THE PROMOTION OF MENTAL HEALTH BE INCLUDED IN AS MANY OF ITS PROGRAMS AS CONSIDERED APPROPRIATE BY THE MEDICAL OFFICER OF HEALTH.

(b) THAT IN ADDITION TO (a) ABOVE, INFORMATION AND ADVICE ON MENTAL HEALTH AND MENTAL ILLNESS IS AVAILABLE, ON REQUEST, TO PERSONS RESIDING IN THE HEALTH UNIT.

(2) THAT AN ONGOING CONTACT BE ESTABLISHED AND MAINTAINED WITH OTHER AGENCIES, INSTITUTIONS AND ORGANIZATIONS INVOLVED IN PROVIDING OR PLANNING MENTAL HEALTH SERVICES IN THE HEALTH UNIT IN ORDER TO PROMOTE THE BOARDS PROGRAMS AND TO AVOID DUPLICATION OF SERVICE.

(3) THAT PROCEDURES BE DEVELOPED AND IMPLEMENTED TO IDENTIFY PERSONS AT RISK FOR MENTAL ILLNESS.

(4) THAT DIRECT SERVICES BE PROVIDED TO PERSONS WITH MENTAL ILLNESS AND THEIR FAMILIES; SUCH SERVICES TO INCLUDE BUT NOT BE LIMITED TO:

(i) SCREENING.

(ii) ASSESSMENT.

(iii) REFERRAL AND FOLLOW-UP.

(iv) FAMILY AND COMMUNITY SUPPORT.

(v) ENCOURAGEMENT OF COMPLIANCE WITH TREATMENT.

IMPLEMENTATION

(1) Program Administration

(a) The Medical Officer of Health shall be responsibile for ensuring the preparation of an annual operational plan pertaining to the Standard.

(b) Records shall be maintained indicating the following:

(i) Source of referral.

(ii) Number of referrals.

(iii) Reason for referral.

(iv) Disposition of referral.

(v) Number of home visits.

(vi) Number of office interviews.

(vii) Type of service provided.

(viii) Number of interagency meetings held.

(ix) Cost of service.

(2) Staffing

The services and activities referred to in the Standard may be carried out by public health nurses under the direction of the senior ranking public health nurse, and other staff as considered appropriate.

(3) Program Delivery

(a) The intent of item (1) of the Standard may be met through the provision of public education and information via the mass media, seminars, discussion groups (with guest speaker), health fair, etc.

(b) The intent of item 2 may be met through:

(i) the preparation of a list which identifies the name and functions of other agencies and institutions which provide mental health services,

(ii) the holding of interagency meetings on a regular basis with organizations included in the above list such as the Children's Aid Society, police, clergy, hospital outpatient services etc.

(c) The intent of item (3) of the Standard may be met through the development of a list of criteria or indicators (a "risk indicator" list) which can be used to identify service priorities. Such indicators may include statistics on:

(i) Economic status.

(ii) Educational status.

(iii) Cultural background.

(iv) People living alone.

(v) Utilization rates of mental health and psychiatric services.

(vi) Population mobility.

DEFINITIONS

- community: means the population within the jurisdiction of the local official health agency.
- counselling: includes activities such as allowing individuals, families and groups to ventilate, apply problem-solving techniques and encouraging the development of coping mechanisms. Counselling operates mainly at the level of primary prevention.
- health supervision: monitoring the health status of the individual: this may be assessment of the physical, mental and emotional status of the individual, screening procedures, laboratory tests, counselling and problem-solving.
- high risk group/population: proportion of individuals with shared characteristics such as age, marital status, socio-economic status, who also share an increased vulnerability to a particular disease.
- need: a level of health or ill-health which requires intervention.
- needs assessment: the process of identification of health needs requiring intervention and judgment concerning relative importance and priority.
- program: a variety of activities or services combined to achieve specific goal-oriented objectives.
- screening: routine assessment of a group of individuals to identify the ones with conditions outside the norm.

POOR

QUALITY

ORIGINAL